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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE			
APP VERSION:2	POLICY NUMBER:	APP: IPC-001	APPLIES TO: Hospital Wide
	TITLE:	INFECTION PREVENTION AND CONTROL PROGRAM	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1.0.INTRODUCTION:

- 1.1. AL HARRTH GENERAL HOSPITAL 50 beds provide care as general hospital for All patients in admission, outpatient, visitors, emergence room and family members within the hospital.

2.0.PURPOSE

- 2.1.To develop infection prevention and control program that give guidance and instructions to all health care personnel in AL-HARTH GENERAL HOSPITAL (HGH) for prevention and control of healthcare associated infections among patients, staff, trainees, contract service workers, volunteers, visitors and patients family.

3.0.DEFINITION

- 3.1. **Infection Control** - is a discipline that addressed healthcare-associated infections (HAIs) and aims at preventing them from happening in healthcare settings.
- 3.2. **Surveillance** - continuous observation of a place, person, group, or ongoing activity in order to gather information.

4.0. POLICY:

- 4.1.The hospital should have an Infection Control Program to coordinate all activities related to surveillance, prevention and control of infections.

4.2. **Components Of Infection Control Program:**

4.2.1. **Surveillance**

4.2.1.1.The major elements would include:

- 4.2.1.1.1. Hospital Acquired Infection
- 4.2.1.1.2. Reportable Disease Notification
- 4.2.1.1.3. Hand Hygiene Compliance
- 4.2.1.1.4. Outbreak Analysis
- 4.2.1.1.5. Infection Surveillance Protocols
- 4.2.1.1.6. Feedback



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4.2.1.1.7. Interventions Improvements

4.2.1.2. The surveillance program contains the following parameters:

- 4.2.1.2.1. Definition of infections (CDC Criteria)
- 4.2.1.2.2. Systematic case finding and data collection
- 4.2.1.2.3. Tabulation of data using database and a custom made Excel Program
- 4.2.1.2.4. Analyze and interpret microbiology reports
- 4.2.1.2.5. Reporting of relevant infection control surveillance data to individuals and/or groups for appropriate action.

4.2.2. **Infection Prevention**

4.2.2.1. The major elements would include:

- 4.2.2.1.1. Standard Precautions
- 4.2.2.1.2. Isolation/Precautions Practices
- 4.2.2.1.3. Disinfection/Sterilization(Protocols and Educate)
- 4.2.2.1.4. Product Evaluation
- 4.2.2.1.5. IC Practices/Policies
 - 4.2.2.1.5.1. Patient Care
 - 4.2.2.1.5.2. Environment of Care
 - 4.2.2.1.5.3. Diagnostic & Treatment
 - 4.2.2.1.5.4. Support Areas

4.2.3. **Policy Development**

4.2.3.1. The major elements would include:

- 4.2.3.1.1. Infection prevention and control policies and procedures are developed by the Infection prevention and control staff and approved by Infection prevention and control committee.
- 4.2.3.1.2. Infection prevention and control policies and procedures are collaboratively developed with medical staff, nursing staff and other internal and external relevant stakeholders.
- 4.2.3.1.3. Infection prevention and control policies and



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procedures are organized in one manual.

- 4.2.3.1.4. Infection prevention and control manual is readily available to all relevant staff and in all patient care areas.

4.2.4. **Employee Health**

4.2.4.1. The major elements would include:

- 4.2.4.1.1. Pre-employment counseling and medical services related to screening, immunization and post exposure management.
- 4.2.4.1.2. Immunization Program (to give available vaccination to all health care worker)
- 4.2.4.1.3. PPD conversion rates are calculated and monitored.
- 4.2.4.1.4. Management of Exposure to open pulmonary TB and vaccine-preventable viruses chickenpox, measles, mumps and rubella.
- 4.2.4.1.5. Management of needle prick and sharp injuries.
- 4.2.4.1.6. Work Restriction Management

4.2.5. **Education**

4.2.5.1. There are continuing education on Infection prevention and control practices to staff, families and other caregivers as indicated by their involvement in the care process. The major elements would include:

- 4.2.5.1.1. Development in determination of educational needs of the facility.
- 4.2.5.1.2. New Employee receive an orientation to hospitals Infection prevention and control policies and procedures upon hiring.
- 4.2.5.1.3. Lecture.
- 4.2.5.1.4. BICSL
- 4.2.5.1.5. Implementation of educational programs.
- 4.2.5.1.6. To meet identified needs.
- 4.2.5.1.7. Evaluation of educational programs on regular basis.

4.2.6. **Consultation Liaison Activity**



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4.2.6.1. The major elements would include:

- 4.2.6.1.1. Initiation and discontinuing of isolation / precautions.
- 4.2.6.1.2. Patient Care
- 4.2.6.1.3. Environmental Services
- 4.2.6.1.4. Food/Nutrition
- 4.2.6.1.5. Waste Management
- 4.2.6.1.6. Pharmacy
- 4.2.6.1.7. Laboratories
- 4.2.6.1.8. Facilities
- 4.2.6.1.9. Supplies

4.2.7. **Quarterly Meeting Of The Infection Control Committee**

- 4.2.7.1. Chaired by the hospital director.
- 4.2.7.2. Brief review of surveillance data.
- 4.2.7.3. Review of antibiogram data, MRSA, VRE and multi drug resistant pathogens.
- 4.2.7.4. Review of new policies and procedure.
- 4.2.7.5. Revision of the yearly Infection prevention and control plan.

4.2.8. **Monthly Meeting Of Infection Control Team.**

- 4.2.8.1. Review of surveillance data
- 4.2.8.2. Review of monthly report for infection control activity.

4.3. Statement About The Authority Of Designated Individuals:

- 4.3.1. The hospital infection control committee through its chairperson and members, is vested with the responsibility and authority to institute any appropriate prevention and control measure when it is reasonable to presume that an infectious risk to any patient or personnel exists.
- 4.3.2. The director for the infection prevention and control program of the institution has the responsibility and authority to establish policies and procedures for the instruction of its personnel and for the overall supervision of infection prevention and control activities in its facilities.



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- 4.3.3. Infection control director & treating doctor They have the authority to make decisions for placing a patient in isolation.
- 4.3.4. Infection control committee They have the authority to make decisions for closing a unit , or stopping surgery because of construction risks.

5.0. RESPONSIBILITY:

- 5.1. It responsibilities of the Infection Prevention and Control Department to implement the program within the health care settings.

6.0.PROCEDURE

MISSION:

The infection prevention and control program in AL-HARTH GENERAL HOSPITAL improves the quality of care and reduces risks to patients, staff and visitors from health care associated infections.

VISION :

Best Care For All Without Infection.

VALUES :

- Respect.
- Caring.
- Innovation.
- Accountability.

Scope Of Services:

- Education and performance improvement monitoring.
- Institutional risk assessment and annual plan for achieving infection-related institutional goals.
- Surveillance activities and outbreak investigation
- Development of policies and procedures
- Monitoring of employee related infectious hazards.



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To design and monitor implementation of all measures needed for prevention and infection control.

Consultation liaison activity.

Oversight of maintenance of the environment and medical equipment.

Customers:

Internal

Patient

Hospital Employee

External

Visitors

Patient family

Student trainees

Organization Structure:

The Infection Prevention & Control Department is independent and report directly to the highest administrative hospital authority (Hospital Director).

Times When Care And Services Are Provided (Hours Of Operation)

The Infection Prevention & Control Department is generally staffed Sunday to Thursday, day shift hours (7.30 am – 3.30pm).

After 3.30 PM to 7.30 AM of the next day, the responsibility of infection control is the Nursing Supervisor. In the absence of the Infection Control Practitioners, the Nursing Supervisor will respond to immediate infection control concerns. He/she may consult with the Chairman of the Infection Control Committee and/or the Director of Infection Control for expert advice.

Consultation available 24*7 when necessary for outbreaks and post exposure management etc.

Type Of Staff Who Carry Out These Activities

Infection Control supervisor (expert physician in infection control)



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Infection Control coordinator (Specialist Nurse with experience in infection control)

Infection Control Practitioners (Registered Nurse with experience in infection control).

Location Of Department:

IPC director office is located in main building first floors

7.0. RECOGNIZED STANDARDS AND PRACTICE GUIDELINES:

- 7.1.Ministry of Health (MOH)
- 7.2.Gulf Cooperation Council- Infection Control (GCC-CIC).
- 7.3.Centers For Disease Control (CDC).
- 7.4.Association for Professionals in Infection Control and Epidemiology (APIC).
- 7.5.Central Board Accreditation for Hospital Institutions (CBAHI).
- 7.6.World Health Organization (WHO).

8.0.APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms.Aisha khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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	TITLE:	IPC COMMITTEE & RESPONSIBILITIES	
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1.0. PURPOSE:

- 1.1.To coordinate and supervise the activities of the Infection Prevention Program and to communicate with all departments of the organization is continuous and proactive.

2.0. DEFINITION:

- 2.1. **Committee** – a group of people who are chosen to do a particular job or to make decisions about something.

3.0. POLICY:

- 3.1. The committee consists of multidisciplinary team members.
- 3.2. Membership includes representation from the Medical, Administration, Nursing, Microbiology, Quality Improvement, and Infection Control Departments (the last should include those individuals directly responsible for the management of the infection surveillance and the prevention and control program). Representation from ancillary departments is available for consultative purposes as discussion items dictate. Membership is selected from:
- 3.2.1. Dept. of Internal Medicine - Infectious Disease Specialist
 - 3.2.2. Dept. of Family Medicine (Employee Health)
 - 3.2.3. Dept. of Surgery
 - 3.2.4. Dept. of Nursing
 - 3.2.5. Health Affairs (Public Health)
 - 3.2.6. Hospital Administration
 - 3.2.7. Microbiology Laboratory
 - 3.2.8. Dept. of Infection Prevention and Control:
 - 3.2.8.1. Infection Control Practitioner(s)
 - 3.2.8.2. Environmental Health Specialist



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- 3.2.8.3. Occupational Health Safety Specialist
- 3.2.9. Operating Room
- 3.2.10. Quality Improvement - Health Affairs
- 3.2.11. Others
 - 3.2.11.1. Guest from other departments such as: Cardiology, Ophthalmology, Hematology, Oncology, Employee Health, CSSD, Radiology, Physiotherapy, Dietary, Housekeeping, Laundry and Mortuary.

4.0. RESPONSIBILITY:

- 4.1. Pursue opportunities to improve patient care and clinical performance.
- 4.2. Recommend practices to resolve identified infection control problems in care and performance.
- 4.3. Recommend corrective actions to governing bodies when necessary.
- 4.4. Approve the type of scope of surveillance activities including stratified infection risk, focused infection studies, and prevalence and incidence studies.
- 4.5. Determine the amount of time required to conduct infection surveillance, prevention and control activities based on several parameters:
 - 4.5.1. Needs of the patient population.
 - 4.5.2. Risk factors of the patient population.
 - 4.5.3. Complexity of the services.
 - 4.5.4. Educational needs of the personnel.
 - 4.5.5. Resource and support services available.
- 4.6. Determine the appropriate definitions and criteria to recognize the existence of healthcare-associated infection (HAIs).
- 4.7. Establish a review process that is directed to detect epidemics, clusters of infections and incidences of infections above the usual baseline levels.
- 4.8. Conduct at least annual reviews of the data trend analysis generated by surveillance activities during the past year as well as the effectiveness of prevention and control intervention strategies in reducing nosocomial infection risks and priorities or problems identified in the past year.



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- 4.9. Initiate and conduct epidemiological investigations relating to infection prevention and control of infection incidents.
- 4.10. Establish, review, and approve, at least every two years, all policies and procedures related to infection surveillance and prevention and control activities in all departments/services.
- 4.11. Review and approve the cleaning procedures, agents and schedules that are used throughout the hospital. This review is to be done biannually or more frequently if necessary.

5.0. PROCEDURE:

5.1. Meeting

- 5.1.1. The Committee meets quarterly or as scheduled in each hospital and healthcare facility. Special meetings will be called by the Chair when circumstances dictate.

NB: All matters to be addressed by the Committee should be brought to the attention of the Chairperson, infection control practitioner (ICP), and/or the appropriate Committee member.

5.2. Documentation

- 5.2.1. Discussions, conclusions, recommendations, assignments, actions, and approvals are documented in the minutes of the Committee meetings. Minutes are distributed to each Committee member and are forwarded to other appropriate staff through the Administrative Advisory Committee.

6.0. MATERIAL/EQUIPMENT:

6.1. N/A

7.0. REFERENCE:



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7.1. GCC Manual for Infection Control, 3rd Edition (2018)

8.0. APPROVALS :

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms.Aisha khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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ADMINISTRATIVE POLICY PROCEDURE			
APP VERSION:1	POLICY NUMBER:	APP: IPC-003	APPLIES TO: HOSPITAL WIDE
	TITLE:	STATEMENT OF AUTHORITY	
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1.0. PURPOSE:

- 1.0. To outline a standard framework regarding Infection Prevention and Control Program applicable to this institution.

2.0. DEFINITION:

- 2.1. **Authority** – the power or right to give orders, make decisions, and enforce obedience.

3.0. POLICY:

- 3.1. The Infection Control Committee (ICC) through its chairperson and members is vested with the responsibility and authority to institute any appropriate prevention and control measure when it is reasonable to consider that a danger (infectious) to any patient or personnel exists.

4.0. RESPONSIBILITY:

- 4.1. It responsibility of the Director of Infection Prevention & Control Department to establish policies and procedures for the instruction of HGH personnel and for the overall supervision of infection prevention and control activities in this hospital.

5.0. PROCEDURES:

- 5.1. This statement of authority is reviewed and authenticated at least every two years by the HGH Administration.

6.0. MATERIAL/EQUIPMENT:

- 6.1. N/A

7.0. REFERENCE:

- 7.1. GCC Manual for Infection Control 2nd Edition Manual(2013)




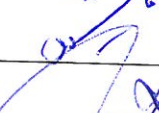

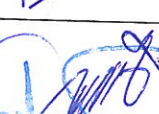


Kingdom of Saudi Arabia
Ministry of Health
Jazan Health Directorate
AL-Harth General Hospital



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE			
APP VERSION:1	POLICY NUMBER:	APP: IPC-003	APPLIES TO: HOSPITAL WIDE
	TITLE:	STATEMENT OF AUTHORITY	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:2 of 2

8.0.APPROVALS :

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms.Aisha khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE			
APP VERSION:1	POLICY NUMBER:	APP: IPC-004	APPLIES TO: Infection Control
	TITLE:	IPC COMMITTEE & RESPONSIBILITIES	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 5

1. PURPOSE

- 1.1. The Infection Prevention and Control Team (IPCT) coordinates an objective and systematic review process to evaluate the quality and appropriateness of patient care as it relates to infection.

2. DEFINITION

- 2.1. N/A

3. POLICY

- 3.1. Infection Prevention and Control Team composed of the following:

- 3.1.1. Infection prevention and control supervisor.
- 3.1.2. Infection prevention and control coordinator.
- 3.1.3. Infection prevention and control Practitioners.
- 3.1.4. Epidemiology Technicians
- 3.1.5. Infection Control Nurse Link

4. RESPONSIBILITY

- 4.1 The Infection Prevention and Control Team

5. PROCEDURES

- 5.1. **Infection prevention and control supervisor** : is responsible for managing and strategizing the Infection prevention and control program including :

- 5.1.1. Responsible for the day to day activities of the infection control team, not full time, but, available at all times for matters of infection control. All the duties of the members of the team are under his direct responsibility.
- 5.1.2. Based on the annual infection prevention risk assessment, develops the infection prevention annual plan.
- 5.1.3. Ensuring coordination of all aspects of the infection prevention and control activities.
- 5.1.4. Ensuring effective implementation of Infection prevention and control policies.
- 5.1.5. Ensuring that healthcare associated infection surveillance is conducted in a systematic manner.

5.2. **Infection prevention and Control coordinator:**

- 5.2.1. Investigate outbreaks and episodes of cross infection with reference to their source, mode of spread and means of control.



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- 5.2.2. Lead the development of active surveillance of health care associated infections, anti-microbial resistant micro-organisms and other "alert" micro-organisms or conditions, including surgical site infection.
- 5.2.3. Ensure mechanism for reporting mandatory infectious diseases, surveillance and critical incidents are maintained.
- 5.2.4. Work in collaboration with the Heads of Clinical Services and Senior Team for infection prevention and control to ensure appropriate implementation and monitoring of infection prevention and control processes.
- 5.2.5. Ensure appropriate and timely investigation of any outbreaks and implementation of the evidence of involvement in developing and delivering education packages.
- 5.2.6. Lead on infection prevention and control in clinical and non-clinical advice across the clinical services.
- 5.2.7. Ensure written protocols / policies are in place, are updated regularly and that implementation and monitoring of practices is undertaken.
- 5.2.8. To facilitate participation in national audit programs and liaise with staff from relevant agencies/departments.
- 5.2.9. Utilize knowledge and experience in the taking of relevant specimens and the interpretation of laboratory results concerning infection prevention and control related to clinical and environmental issues.
- 5.2.10. Working with the designated decontamination leads, ensure appropriate infection prevention and control knowledge and experience is available to support processes, such as cleaning, decontamination and sterilization of equipment used in patient care.
- 5.2.11. To be involved in evaluating new equipment with infection control implications, prior to its purchase.
- 5.2.12. Performing other job relevant duties. Assigned by the Infection prevention and control supervisor.

5.3. Infection Control Practitioners

- 5.3.1. Performs prevalence rounds in all hospital departments to, monitor the infection control practices with staff personnel.
- 5.3.2. Conduct infection control surveillance: collect, tabulate, analyze, and present infection data through review of laboratory data, medical records, and patient unit rounds.
- 5.3.3. Identifies and reports healthcare associated infections (HAI) regularly.
- 5.3.4. Identifies reportable conditions such as tuberculosis and reports as mandated to ministry of health.
- 5.3.5. Implements educational programs to provide staff with knowledge and skills regarding infection control practices.



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE

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- 5.3.6. Participate in revising and updating hospital infection control policies and procedures at least every 3 years and maintains an up-to-date infection control manual.
- 5.3.7. Participates in performance improvement projects and committees as required and needed to eliminate/ reduce healthcare associated infections (HAI).
- 5.3.8. Assesses employees and their environment for injury/illness risks and implements appropriate safety precautions and follow up procedures.
- 5.3.9. Performs post-exposure follow-up as needed, including hospital staff, patients and first responders, coordinating with employee health as appropriate.
- 5.3.10. Assesses patients for risk of transmission or exposure to infections and implements appropriate safety isolation precautions and follow up procedures.
- 5.3.11. Ensures the availability of place and supplies required for isolation.
- 5.3.12. Collaborates with CSSD staff in all matters related to sterilization and infection control practices.
- 5.3.13. Participate in the evaluation and implementation of various aspects of the waste disposal program.
- 5.3.14. Performs other job-related duties assigned.

5.4. Epidemiology Technician / Public Health

- 5.4.1. Receive notification of infectious/communicable diseases and complete the requested information before reporting electronically through Health Electronic System Network (HESN).
- 5.4.2. Apply epidemiologic principles and statistical methods, including risk stratification, to identify target population, analyze trends and risk factors, and design and evaluate prevention and control strategies.
- 5.4.3. Assess environmental control through surveillance of water supply systems as needed, air pressure relationships for high risk environmental monitoring.
- 5.4.4. Conduct environmental rounds in all inpatient and outpatient care areas. Collect data on the incidence of selected device use.
- 5.4.5. Report epidemiologically significant findings to appropriate customers.
- 5.4.6. Evaluate the effectiveness of the surveillance plan and modifies as necessary.
- 5.4.7. Report all patients with communicable disease to the health department and maintain appropriate records. Compile and interpret surveillance reports to Infection Control committee, specialty areas, and executive medical committee on a regular basis.
- 5.4.8. Collect data in support of epidemiological studies of specific problems or problem areas to determine the source of the problem and make appropriate recommendations.
- 5.4.9. Assist in the organization of regularly scheduled Hospital Infection Control meetings and dissemination of recommendations hospital-wide.



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5.4.10. Plan, organize, develop and implement educational programs for all hospital employees including administrative and ancillary services which convey specialized knowledge and skills to increase employee awareness of existence of communicable disease; techniques for avoidance and preventive measures to provide a safe environment for hospital employees and patients.

5.5. Infection Control Link Nurse (ICLN)

5.5.1. An effective way to develop Infection Prevention & Control education and operational support can be through a link system. These individuals have special responsibility for maintaining good infection prevention & control practices and education within their departments.

5.5.1.1. The ICLN is the "link" between the Infection Control Team and the ward and helps identify problems, implements solutions and maintains communication.

5.5.1.2. A competent ICLN can motivate ward staff by enabling more effective practice.

5.5.1.3. Provide accurate information regarding potential or actual infection control problems to the Infection Control Team and assist in outbreaks as required.

5.5.1.4. Monitoring hygiene, consistent with policy and procedures.

5.5.1.5. Reporting promptly to the attending physician any evidence of infection in patients.

5.5.1.6. Provide education to staff of the clinical unit in relation to infection control practices.

5.5.1.7. Monitoring aseptic techniques, including hand hygiene and use of isolation precautions.

6. ATTACHMENTS

6.1. JOB DESCRIPTION FOR IPC TEAM

7. REFERENCES:

7.1. General directorate of Infection Prevention & Control (GDIPC) RIYAD 2016.

7.2. APIC Text of Infection Control and Epidemiology, 2016.



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

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8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
	Mr. Khalid Mohajab	Head of Public Health		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms.Aisha khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE			
APP VERSION:1	POLICY NUMBER:	APP: IPC-005	APPLIES TO: HOSPITAL WIDE
	TITLE:	REQUESTING INFECTION CONTROL REVIEW AND CONSULTATION	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 2

1.0. PURPOSE:

- 1.1. To provide quality patient care through education and practical application of the principles of microbiology, epidemiology and infection prevention and control.

2.0. DEFINITION:

- 2.1. N/A

3.0. POLICY:

- 3.1. Infection control is Everyone's Responsibility, but the scope and magnitude encompassed by Infection Control requires a "key person" to coordinate the activities of the program. The Infection Control Practitioner (ICP) is that "key person."
- 3.2. The Infection Control Staff must have knowledge and expertise in microbiology, epidemiology, sterilization and disinfection, infectious diseases, antiseptic usage, clinical practices and statistics to function in this pivotal role as educator, investigator, researcher, patient advocate, agent of change, consultant, statistician, sanitarian, role model, coordinator, and diplomat.

4.0. RESPONSIBILITY:

- 4.1. It is the responsibility of all staffs to follow infection control measures in the hospital.

5.0. PROCEDURE:

- 5.1. Request infection control review and consultation as they relate to infection prevention and control activities such as:
- 5.1.1. Surveillance
 - 5.1.2. Investigation
 - 5.1.3. Research
 - 5.1.4. Statistics
 - 5.1.5. Education
 - 5.1.5.1. Staff



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	TITLE:	REQUESTING INFECTION CONTROL REVIEW AND CONSULTATION	
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5.1.5.2. Patient
5.1.5.3. Visitors

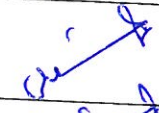
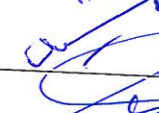




6.0. MATERIAL/EQUIPMENT:

6.1. N/A

7.0. REFERENCE:

7.1. GCC Manual for Infection Control 3rd Edition Manual(2018)

8.0. APPROVALS :

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Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE

APP VERSION:1	POLICY NUMBER:	APP: IPC-006	APPLIES TO: All Hospital staff
	TITLE:	Basic Infection Control Skill License (BICSL)	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 3

1.0. PURPOSE:

- 1.1. To improve best practice of basic Infection Prevention and Control Procedures in their healthcare institutes .
- 1.2. To decrease healthcare associated infections among healthcare employee, Patient visitors .

2.0. DEFINITIONS:

- 2.1. BICSL : It is an abbreviation of Basic Infection Control Skills License ,Components of BICSL:

3.0. RESPONSABILITIES :

- 3.1. All employee who got BICSL : must implement is components in their healthcare institutes
- 3.2. Regional Directorate of IPC : monitor BICSL requirements implementation in all healthcare facilities by staff .

4.0. POLICY :

- 4.1. BICSL must be applied for all healthcare employee who are in contact with patients .
- 4.2. N95 respirator fit testing is applied only for Healthcare workers .
- 4.3. BICSL certificate is valid for one year .
- 4.4. N95 respirator fit testing is valid for two years .

5.0. PROCEDURES :

- 5.1. BICSL Includes one to one training about :
 - 5.1.1. Hand hygiene (how to hand wash and how to hand rub).
 - 5.1.2. Personal Protective Equipment use.
 - 5.1.3. Respirator(N95)Fit Testing Techniques.
 - 5.1.4. Injection Safety Practice
- 5.2. Trainer of BICSL:
 - 5.2.1. Must be skilled enough to train participants



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE

APP VERSION:1	POLICY NUMBER:	APP: IPC-006	APPLIES TO: All Hospital staff
	TITLE:	Basic Infection Control Skill License (BICSL)	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:3 of 3

8.0. APPROVALS

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	BICSL coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms.Aisha khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





Department of infection prevention and control

THE NEWLY HIRED STAFF ORIENTATION CHECKLIST

name	age	sex	nationality
Job title	department	Employee #	

1) Introduction to infection control a- Ipc department/committee b- Function of ipc department/committee c- Availability and location of IPC manuel	Staff/student signature
2) Employee health screening and vaccination	
3) Hand hygiene	
4) Epidemiology of infection	
5) Standard precautions	
6) Expanded precaution (isolation precautions) a- Contact b- Airborn c- Droplet	
7) Management of selected airborne/droplet infectious disease among HCWs	
8) Guidance for the use of PPE (Personal Protective Equipment) a- Donning OF PPE b- Removal and Disposal of PPE	
9) Occupational blood exposure Management (sharps & body fluids)	
10) Spill kit management	
11) Medical waste management	
12) Decontamination of patient care	

Oriented by

IPC Staff Name

Signature

Date

IPC Staff Name

Signature

Date

NOTE: signing the column " indicates that the new hired staff is fully understood the given orientation



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE			
APP VERSION:1	POLICY NUMBER:	APP: IPC-007	APPLIES TO: HOSPITAL WIDE
	TITLE:	STAFF ORINATION	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
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1.0. PURPOSE:

- 1.1. To provide guidelines on giving orientation program to hospital staff.

2.0. DEFINITION:

- 2.1. N/A

3.0. POLICY:

- 3.1. Upon hire, all hospital personnel should receive an Infection Control Orientation prior to commencement of duties including:

- 3.1.1. Doctors
- 3.1.2. Nurses
- 3.1.3. Other paramedical staff (e.g., Medical Technologists, Radiological Technicians, Respiratory therapist, etc.)
- 3.1.4. Support services staff (e.g. Kitchen, Laundry, Medical Waste, CSSD, etc.)

4.0. RESPONSIBILITY:

- 4.1. It is the responsibility of the infection control department to implement guidelines to all hospital staff about infection control.

5.0. PROCEDURE:

- 5.1. Upon hire, after undergoing General Medical Screening from the Staff Clinic, the newly hired staff should be scheduled for Orientation in the Infection Control Department.
- 5.2. Schedule for the orientations can be obtained from Infection Control Department thru a written request.
- 5.3. The Department Head should write a request for Orientation Schedule from Infection Control Department.
The written request for schedule should include the list of all newly-hired staff that will be sent for orientation.
- 5.4. Infection Control Department will respond with a written acknowledgement stating the date of orientation schedule.
- 5.5. Infection Control Orientation is being held every Monday And Thursday between 10:00 am to 12:00 pm venue for which depends on the number of scheduled staff.



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5.6. Please refer to the **Infection Control Orientation Checklist** for the topics.

6.0. MATERIAL/ATTACHMENT :

6.1. **Infection Control Orientation checklist**

7.0. REFERENCE:

7.1. GCC Manual for Infection Control, 3rd Edition (2018)



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8.0. APPROVALS :

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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE			
APP VERSION:1	POLICY NUMBER:	APP: IPC-008	APPLIES TO: hospital wide
	TITLE:	PATIENT AND FAMILY EDUCATION	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 5

1. PURPOSE

- 1.1 To reduce the risk of infection transmission of the disease.

2. RESPONSIBILITY

N/A

3. DEFINITION

- 3.1 **Isolation** is defined as the separation or restriction of activities of an ill person with a contagious disease from those who are Well.

4. POLICY

- 4.0 Assess whether the home is suitable and appropriate for isolating the ill person. You can conduct this assessment by phone or direct observation.
- 4.1 The home should have a functioning bathroom. If there are multiple bathrooms, one should be designated solely for the ill person.
- 4.2 The ill person should have his or her own bed and preferably a private room for sleeping.
- 4.3 There should be a primary caregiver who can follow the healthcare provider's instruction for medications and care. The caregiver should help the ill person .

5. PROCEDURES:

5.0 Patient:

- 5.0.1 Separate yourself from other people in your home :
- 5.0.1.1 As much as possible, you should stay in a different room from other people in your home.
- 5.0.1.2 Also, should use a separate bathroom, if available.
- 5.0.2 Call ahead before visiting your doctor :
- 5.0.2.1 Before your medical appointment, call the healthcare provider and tell him or her that you may have MERS-CoV infection. This will help the healthcare provider's office take step to keep other people from getting infected.
- 5.0.3 Wear a medical mask :
- 5.0.3.1 You should wear a medical mask when you are in the same room with other people and When you Visit a healthcare provider. If you cannot wear a medical mask, the people Who live With you should wear one While they are in the same room with you.
- 5.0.4 Cover your coughs and sneezes:



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- 5.0.4.1 Cover your mouth and nose with a tissue when you cough or sneeze, or you can cough or sneeze into your sleeve. Throw used tissues in a lined trash can, and immediately wash your hands with soap and water or disinfect it with waterless alcohol-based hand sanitizer.
- 5.0.5 Wash your hands.
- 5.0.5.1 Wash your hands often and thoroughly with antiseptic soap and water. You can use an alcohol based hand sanitizer if antiseptic soap and water are not available and if your hands are not visibly dirty. Avoid touching your eyes, nose, and mouth with unwashed hands.
- 5.0.6 Avoid sharing household items:
- 5.0.6.1 You should not share dishes, drinking glasses, cups, eating utensils, towels, bedding, or other items with other people in your home. After using these items, you should wash them thoroughly with soap and warm water.
- 5.1 **For Family members and caregivers :**
- 5.1.1 If you live with or care for someone at home who is ill and being evaluated for MERS-CoV infection, you should:
- 5.1.1.1 Make sure that you understand and can help the ill person follow the healthcare provider's instructions for medication and care. You should help the ill person with basic needs in the home and provide support for getting groceries, prescriptions, and other personal needs.
- 5.1.2 Have only people in the home who are essential for providing care for the ill person.
- 5.1.2.1 Other household members should stay in another home or place of residence. If this is not possible, they should stay in another room, or be separated from the ill person as much as possible. Use a separate bathroom, if available.
- 5.1.2.2 Restrict Visitors Who do not have an essential need to be in the home.
- 5.1.2.3 Keep elderly people and those who have compromised immune systems or specific health conditions away from the ill person. This includes people with chronic heart, lung or kidney diseases, and diabetes.
- 5.1.3 Make sure that shared spaces in the home have good airflow, such as by air-conditioner or an opened window.



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- 5.1.4 Wear a disposable medical mask, gown, and gloves when you touch or have contact With the ill person's blood, body fluids and/or secretions, such as sweat, saliva, sputum, nasal mucous, Vomit, urine, or diarrhea.
 - 5.1.4.1 Throw out disposable medical masks, gowns, and gloves after using them. Do not reuse.
 - 5.1.4.2 Wash your hands immediately after removing your medical mask, gown, and gloves.
- 5.1.5 Wash your hands often and thoroughly with soap and water. You can use an alcohol-based hand sanitizer if soap and water are not available and if your hands are not visibly dirty. Avoid touching your eyes, nose, and mouth with unwashed hands.
- 5.1.6 Avoid sharing household items. You should not share dishes, drinking glasses, cups, eating utensils, towels, bedding, or other items with an ill person who is being evaluated for MERS-CoV infection. After the ill person uses these items, you should wash them thoroughly with soap and Warm Water.
- 5.1.7 Clean all "high-touch" surfaces every day. Also, clean any surfaces that may have blood, body fluids and/or secretions on them.
 - 5.1.7.1 Wear disposable gloves and gown while cleaning surfaces.
 - 5.1.7.2 Clean frequently touched surfaces such as bedside tables, bed frame, and other bedroom furniture daily with regular household cleaners or a diluted bleach Solution. Clean bathroom and toilet surfaces daily with regular household cleaners or a diluted bleach solution.
- 5.1.8 Wash laundry thoroughly.
 - 5.1.8.1 Immediately remove and wash clothes or bedding that have blood, body fluids and/or secretions on them.
 - 5.1.8.2 Wear disposable gloves while handling soiled items. Wash your hands immediately after removing your gloves.
 - 5.1.8.3 Wash the items with detergent and warm water at the maximum available cycle length then machine dry them.
- 5.1.9 Place all used gloves, gowns, medical masks, and other contaminated items in a lined container before disposing them with other household waste. Wash your hands immediately after handling these items.
- 5.1.10 For close contacts including healthcare providers; If you have had close contact with someone who is ill and being evaluated for MERS-CoV infection, you should:



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5.1.10.1 Monitor your health for 14 days, starting from the day you were last exposed to the ill person. Watch for these symptoms.

- Fever (38°C, or higher). Take your temperature twice a day.
- Coughing.
- Shortness of breath.
- Other early symptoms to watch for are chills, body aches, sore throat, headache, diarrhea, nausea/vomiting, and runny nose.

5.1.11 If you develop symptoms, follow the prevention steps described above, and call 937 or your healthcare provider as soon as possible. Before your medical appointment, call the healthcare provider and tell him or her about your possible exposure to MERS-CoV. This will help the healthcare provider's office take steps to keep other people from getting infected.

5.1.12 If you do not have any of the symptoms, you can continue with your daily activities, such as going to Work, School, or other public areas.

6. ATTACHEMENT

6.1 N/A

7. REFERENCES

7.1 Infection Prevention and Control Guidelines for Middle East Respiratory Syndrome Corona virus (MERS-CoV) Infection. 5.1 Edition may 21 2018



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	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Mohammed Alwany	Health Education Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms.Aisha khubrani	Quality Director		13-7-2021
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1.0. PURPOSE:

- 1.1. To provide guidelines on the basic infection control practices to prevent the transmission of infectious agents during patient-healthcare worker daily interactions.

2.0. DEFINITION:

- 2.1. **Standard precautions** – methods of infection prevention and control which all human body substances except sweat are considered infectious regardless of their status.

3.0. POLICY:

- 3.1. Standard Precautions should be used for all patients to reduce the transmission of microorganisms from recognized and unrecognized sources of infection in hospital.

4.0. RESPONSIBILITY:

- 4.1. All health care workers must apply the standard precautions while dealing with the patients, blood, body fluids, and etc.

5.0. PROCEDURE:

5.1. Hand Hygiene

- 5.1.1. Methods of HH involve either antibacterial soap and water or alcohol-based waterless hand rub. HH is used to remove or kill microorganisms that colonize the hands.
- 5.1.2. The WHO's 5 moments for HH:
- 5.1.2.1. Before patient contact
- 5.1.2.2. Before aseptic tasks



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- 5.1.2.3. After body fluid exposure risk
- 5.1.2.4. After patient contact
- 5.1.2.5. After contact with patient surroundings/environment
- 5.1.3. Refer to **Hand Hygiene policy**.

5.2. Personal Protective Equipment (PPE)

- 5.2.1. PPE is used to create a barrier between HCWs and patients, substances, or surfaces. Use appropriate PPE (gloves/gowns/plastic aprons/eye protection) to prevent skin and mucous membrane exposure. Use one or more of these items based on the degree and risk of exposure. However, most routine patient care activities at the bedside do not require the use of PPE.

5.2.1.1. Gloves

- 5.2.1.1.1. Wear gloves whenever in contact with blood, other body substances or contaminated items and surfaces and when in an isolation room.
- 5.2.1.1.2. Wear and change gloves between tasks/procedures on the same patient.
- 5.2.1.1.3. Remove gloves promptly after use and before touching clean items and environmental surfaces.
- 5.2.1.1.4. Perform hand hygiene immediately after removing gloves.
- 5.2.1.1.5. Gloves are not to be worn after leaving the patient room or procedure area.
- 5.2.1.1.6. Use non-sterile gloves for examinations and other clean procedures, and use sterile gloves for sterile procedures.

5.2.1.2. Gowns/plastic aprons

- 5.2.1.2.1. Wear a gown/plastic apron to protect skin and clothing during procedures that may generate splashes or aerosolization of body substances and cause the soiling of clothes.
- 5.2.1.2.2. Securely fasten the tabs/ties to keep the gown/plastic apron in place while performing patient care activities in the patient room/procedure area.
- 5.2.1.2.3. Remove the gown/plastic apron by untying the tabs/ties and folding it away from you in an inside-out manner. Roll it into a ball and discard.



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5.2.1.2.4. Change the gown/plastic apron for each patient and/or procedure.

5.2.1.2.5. Gloves/aprons are not to be worn after leaving the patient room or procedure area.

5.2.1.3. Mask (surgical or N95)

5.2.1.3.1. Wear a surgical mask (with protective eye/face wear) if splashing or aerosolization of blood or body fluids is expected.

5.2.1.3.2. Change mask between patients and sooner if mask becomes wet, moist or torn.

5.2.1.3.3. Wear an N95 mask when indicated to enter an airborne isolation room, and remove it only when outside of the room.

5.2.1.4. Protective eye/face wear

5.2.1.4.1. Wear protective eye/face wear if required for combined protection from eye/face contamination by aerosolized body substances.

5.2.1.4.2. Wash and disinfect visibly soiled reusable face shields or protective eyewear prior to reuse.

5.3. Handling/disposal of contaminated items

5.3.1. Needles/sharps

5.3.1.1. Dispose of used sharp items in an approved puncture-resistant container immediately after use, at the point of use or as close to point of use as possible.

5.3.1.2. Do not place used sharp items on any environmental surface.

5.3.1.3. Do not recap or manipulate needles using both hands because this increases the risk of injury. If recapping or manipulation of the needle is deemed essential, then use either a one-handed "scoop" technique or a mechanical device designed to hold the needle sheath.

5.3.1.4. Before attempting to remove needles from reusable aspirating syringes, recap them with either a one-handed "scoop" technique or a mechanical device designed to hold the needle sheath.

5.3.1.5. Close sharps containers when $\frac{3}{4}$ full and remove for incineration.

5.3.2. Linen

5.3.2.1. Linen should be handled and transported in a manner to prevent skin/mucous membrane exposure and contamination of clothing



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or transferring microorganisms to other patients or the environment.

5.3.2.2. Place wet/heavily soiled linen in a designated impermeable bag and close the bag securely or wrap wet linen in another piece of linen to avoid soaking of the bag.

5.3.2.3. Refer to **Laundry policy**.

5.3.3. **Medical waste**

5.3.3.1. Place biomedical waste in identifiable (color-coded) bags or appropriate containers.

5.3.3.2. Securely tie or close bags/containers and remove for appropriate disposal.

5.3.3.3. Refer to **Waste Management policy**.

5.3.4. **Patient care equipment**

5.3.4.1. Handle used patient care equipment in a manner that prevents skin and mucous membrane exposure, contamination of clothing and transfer of microorganisms to other patients or the environment.

5.3.4.2. Commonly used equipment must be clean and disinfected between patients.

5.3.4.3. Do not reuse single-use disposable equipment.

5.3.4.4. Ensure that reusable equipment is properly transported in leak-proof containers to CSSD for reprocessing before use with another patient.

5.3.5. **Laboratory specimens**

5.3.5.1. Handle all specimens with gloves.

5.3.5.2. Place laboratory specimens in designated, appropriately sealed containers.

5.3.5.3. Label containers with appropriate patient data.

5.3.5.4. Transfer to the laboratory in an upright position as promptly as possible.

5.3.5.5. Ensure that the requisition has the complete information (i.e., specification site, which is critical for lab analysis and clinical interpretation).

5.3.6. **Room cleaning**

5.3.6.1. Rooms should be cleaned daily and after patient discharge.

5.3.6.2. Cleaning is required as per **Housekeeping policies**.

5.3.7. **Patient placement**



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5.3.7.1. Place patients who pose a risk of transmission to others (e.g., those with uncontained secretions, excretions, or wound drainage or infants with suspected viral respiratory tract or gastrointestinal tract infections) in single-patient rooms when available.

5.3.8. **Cough etiquette**

5.3.8.1. Cover nose and mouth with a tissue when coughing or sneezing.

Refer to [IPC-09-01](#)

5.3.8.2. Dispose of the used tissue in the nearest waste receptacle.

5.3.8.2.1. Clean hands with soap and water or antiseptic solution or with an alcohol-based hand rub after touching respiratory secretions or handling contaminated objects.

6.0. MATERIAL/EQUIPMENT:

6.1. Hand sanitizer and soap

6.2. PPE (Personal Protective Equipment)

7.0.REFERENCE:

7.1. GCC Manual for Infection Control 3rd Edition Manual(2018)



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8.0. APPROVALS :

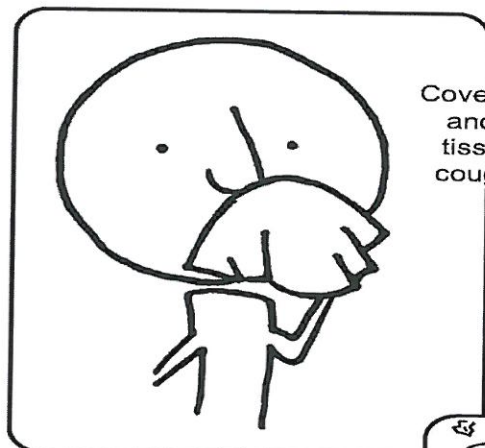
	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
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	Ms. Aisha Khubrani	Quality Director		13-7-2021
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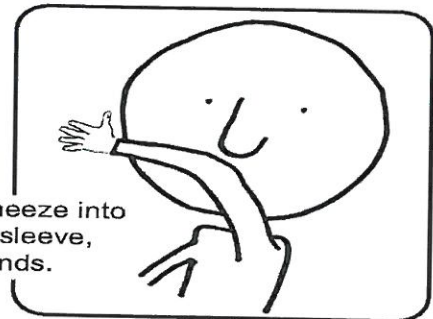
Figure IPC-09-01

COUGH ETIQUETTE

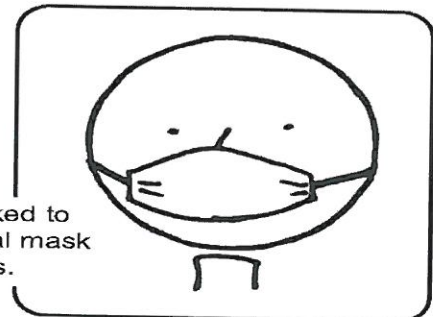
Cover your Cough



Cover your mouth
and nose with a
tissue when you
cough or sneeze
or
cough or sneeze into
your upper sleeve,
not your hands.



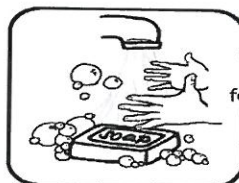
Put your used tissue in
the waste basket.



You may be asked to
put on a surgical mask
to protect others.

Clean your Hands

after coughing or sneezing.



Wash hands
with soap and
warm water
for 20 seconds or

clean with
alcohol-based
hand cleaner.





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1. PURPOSE

- 1.1 To emphasize the importance of hand hygiene (HH) as the single most effective measure for preventing disease transmission in the healthcare setting; and, to describe indications and techniques for hand hygiene.

2. DEFINITION COMMENTS

- 2.1 Hands may easily become contaminated with infectious microorganisms, which can enter the body through a break in the skin or be transmitted to a susceptible host and cause infection.
- 2.2 All personnel, physicians, nurses, technicians and others who are responsible for complying with the hand hygiene policy should lead by example and call observed infractions to the attention of any offenders.
- 2.3 Artificial nails and chipped nail polish may be associated with an increase in the number of bacteria on finger nails and should not be used.
- 2.4 Resident flora (resident bacteria) refers to the microorganisms residing under the superficial cells of the stratum corneum and also found on the surface of the skin.
- 2.5 Transient flora (transient bacteria) refers to the microorganisms that colonize the superficial layers of the skin and are easily removed by routine hand hygiene.

3. POLICY

- 3.1 All staff must perform the 5 Moments for Hand Hygiene :
 - 3.1.1 **(Indications for Hand Hygiene) Clean your hands:**
 - 3.1.1.1 Before touching a patient.
 - 3.1.1.2 Before clean/aseptic procedures.
 - 3.1.1.3 After body fluid exposure risk.
 - 3.1.1.4 After touching a patient.
 - 3.1.1.5 After touching patient's surroundings.
- 3.2 **Other Opportunities for Hand Hygiene**
 - 3.2.1 When hands are visibly soiled.
 - 3.2.2 After contact with a source of microorganisms (body fluids and substances, mucous membranes, non-intact skin, surfaces that are likely to be contaminated).
 - 3.2.3 After removing gloves.
 - 3.2.4 Before and after smoking, eating or preparing food.
 - 3.2.5 Before leaving the patient's room.
 - 3.2.6 After bodily functions (e.g., using the toilet, blowing one's nose, sneezing).
 - 3.2.7 When moving from a contaminated body site to a clean body site during patient care.



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- 3.3 **Hands and other skin surfaces exposed to blood or body fluids must be cleansed as soon as patient safety permits.**

4. **PROCEDURE :**

- 4.1 **Hand washing :** Wash hands for a minimum of 40-60 seconds
- 4.1.1 Remove excess jewelry.
 - 4.1.2 Select a comfortable water temperature.
 - 4.1.3 Wet hands with running water.
 - 4.1.4 Apply soap to cover all surfaces of the hands.
 - 4.1.5 Rub hands palm to palm.
 - 4.1.6 Right palm over left dorsum with interlaced fingers and vice versa.
 - 4.1.7 Palm to palm with fingers interlaced.
 - 4.1.8 Backs of fingers to opposing palms with fingers interlaced.
 - 4.1.9 Rotational rubbing of the left thumb clasped in the right palm and vice versa.
 - 4.1.10 Rotational rubbing backward and forward with clasped fingers of the right hand in the left palm and vice versa.
 - 4.1.11 Rinse the hands with running water to remove all soap residue, holding hands in upward position over sink.
 - 4.1.12 Dry the hands with a paper towel.
 - 4.1.13 Turn the faucet off with the used paper towel.
 - 4.1.14 **Techniques : (Refer to Appendix IPC-10-1)**
- 4.2 **Hand rubbing :**
- 4.2.1 Use alcohol-based hand antiseptic rub for a minimum of 20-30 seconds.
 - 4.2.1.1 Apply to dry, visibly clean hands.
 - 4.2.1.2 Rub hands vigorously to apply hand antiseptic to all surfaces of hands
 - 4.2.1.3 Rub hands palm to palm.
 - 4.2.1.4 Right palm over left dorsum with interlaced fingers and vice versa.
 - 4.2.1.5 Palm to palm with fingers interlaced.
 - 4.2.1.6 Backs of fingers to opposing palms with fingers interlaced.
 - 4.2.1.7 Rotational rubbing of the left thumb clasped in the right palm and vice versa.
 - 4.2.1.8 Rotational rubbing backward and forward with clasped fingers of the right hand in the left palm and vice versa.
 - 4.2.1.9 Allow hands to dry
 - 4.2.1.10 **Techniques : (Refer to Appendix IPC-10-2)**



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- 4.3 **Use only soap and water :** when dealing with spore-forming bacteria (e.g., clostridium difficile) and/or when your hands are visibly soiled.
- 4.4 **Care of hands:**
- 4.4.1 Use hand moisturizers to replace the oils lost by frequent hand hygiene procedures.
- 4.4.2 Ensure that the skin on your hands is intact. Cover non-intact skin areas with an occlusive dressing.
- 4.4.3 Do not use petroleum-based lotions, as they may interfere with glove integrity.
- 4.5 **Medical assessment:**
- 4.5.1 Any suspicion of a dermatological condition must be evaluated by an Employee Health Physician or the appropriate medical service.
- 4.5.2 HCWs that have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient care equipment until the condition resolves.
- 4.6 **Use of gloves:**
- 4.6.1 The use of gloves does not replace the need for hand hygiene.
- 4.6.2 Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, or non-intact skin will occur.
- 4.6.3 Remove gloves after any procedure with a patient.
- 4.6.4 Change or remove gloves during patient care if moving from a contaminated body site to either another body site (including non-intact skin, mucous membrane or a medical device) within the same patient or the environment.
- 4.6.5 Change gloves between patients.
- 4.6.6 Identify the correct type of glove to be used (Refer Appendix IPC-10-3)
- 4.7 **Surgical hand hygiene: (Refer to Appendix IPC-10-4)**
- 4.7.1 Before starting surgical hand hygiene preparation (hand scrub or hand rub)
- 4.7.1.1 Remove all jewelry and wristwatches before entering the operating room (OR) suite.
- 4.7.1.2 Wash hands and arms up to the elbows with a non-medicated soap before entering the OR area.
- 4.7.1.3 Use a nail cleaner for the first surgical hand scrub of the day.
- 4.7.2 Surgical hand scrub with antimicrobial soap
- 4.7.2.1 Start timing and then scrub each side of each finger, between the fingers and the back and front of the hand for two minutes.



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- 4.7.2.2 Scrub the arms, keeping hands higher than the arms at all times.
- 4.7.2.3 Wash each side of the arm from wrist to the elbow for one minute, repeating the process on the other hand and arm.
- 4.7.2.4 Rinse hands and arms by passing them through the water in one direction (from fingertip to elbow), always keeping the hands above the elbows.
- 4.7.2.5 Proceed to the OR holding hands above the elbows.
- 4.7.2.6 Dry hands with a sterile towel and use aseptic technique to put on gloves.
- 4.7.2.7 NB: The duration of the procedure depends on the ingredients and the manufacturer's instructions (can range from 2-6 minutes).
- 4.7.3 Surgical hand rub with alcohol-base preparation
 - 4.7.3.1 Start timing.
 - 4.7.3.2 Use sufficient product to keep hands and forearms wet with the hand rub throughout the procedure.
 - 4.7.3.3 See attachment for proper technique.
 - 4.7.3.4 After application of the product, allow hands and forearms to dry before donning sterile gloves.
 - 4.7.3.5 Proceed to the OR holding hands above the elbows.
 - 4.7.3.6 NB: The duration of the procedure depends on the ingredients and the manufacturer's instructions (can range from 2-6 min) and should last until hands are dry.
- 4.7.4 Use of brushes
 - 4.7.4.1 Use of brushes is discouraged.
 - 4.7.4.2 A disposable sponge or a combination of a sponge and brush has been shown to reduce bacterial counts on the hands.
- 4.8 Hand hygiene compliance surveillance
 - 4.8.1 Target department (ER, Male ward and female ward)
 - 4.8.2 Use WHO observation form to monitoring hand hygiene compliance rate (Refer to Appendix IPC-10-5)
 - 4.8.3 Minimum Oppourinty each department 25 oppourinty.
 - 4.8.4 compliance Rate = hand hygiene action /total oppourinty*100
 - 4.8.5 Distribution monthly hand hygiene compliance rate to medical director,nursing directot, target department and Discussed in infection control committee.

5. EQUIPMENTS

5.1 Water

- 5.1.1 Water is described as the universal solvent for a large number of substances.



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- 5.1.2 When used alone, water cannot remove dirt from hands.
- 5.2 **Drying Methods**
- 5.2.1 Drying practice is a critical factor to determine the level of bacterial residue.
- 5.2.2 Use paper towels.
- 5.2.3 Pat the skin dry rather than rub it to avoid cracking (skin excoriation may lead to bacteria colonizing the skin).
- 5.2.4 Do not reuse or share hand drying towels.
- 5.3 **Plain (non-antimicrobial) soap**
- 5.3.1 These soaps are detergent-based and will remove lipids and adhering dirt and organic matter.
- 5.3.2 They have no antimicrobial activity.
- 5.3.3 Such soaps can remove transient flora from the skin.
- 5.4 **Antimicrobial soap**
- 5.4.1 These soaps are detergent-based and will remove lipids, adhering dirt and organic matter.
- 5.4.2 They have antimicrobial activity.
- 5.4.3 They can remove transient and resident flora from the skin.
- 5.5 **Alcohols**
- 5.5.1 Alcohol-based hand antiseptics contain ethanol, isopropanol, n-propanol or a combination of two of these products.
- 5.5.2 They have the ability to denature proteins
- 5.5.3 The most effective solutions contain 60%-80% alcohol (a higher concentration is less effective).
- 5.5.4 They are rapidly germicidal.
- 5.5.5 Such antiseptics are available in gels, liquid, and foam.

6. ATTACHMENT

- 6.1 Appendix 1: Handwashing Techniques
- 6.2 Appendix 2: Hand Rub Techniques
- 6.3 Appendix 3: Pyramid on Glove Use.
- 6.4 Appendix 4: Surgical Hand Hygiene
- 6.5 Appendix 5: WHO Hand Hygiene Observation Form.



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE

APP

VERSION:1

POLICY NUMBER:

TITLE:

APPROVAL DATE:

DUE FOR REVIEW:

APP: IPC-010

HAND HYGIENE

JUL 30,2021

JUL 30,2023

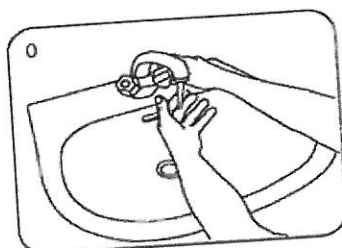
APPLIES TO: HOSPITAL WIDE

EFFECTIVE DATE: AUG 30,2021

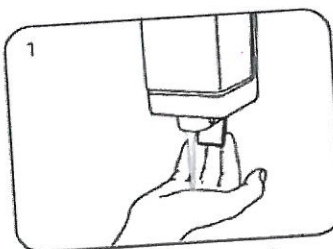
NUMBER OF PAGES:6 of 11

Appendix IPC-10-1: Handwashing Techniques

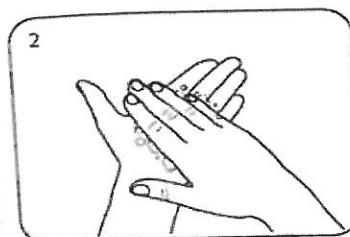
Handwashing Technique with Soap and Water



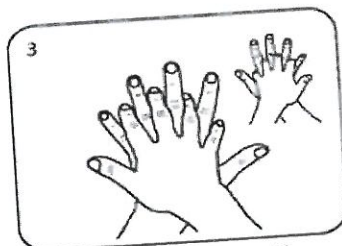
Wet hands with water



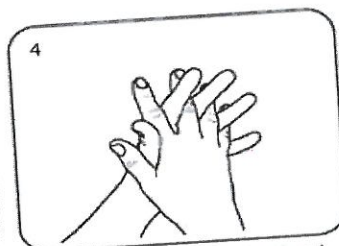
apply enough soap to cover all surfaces



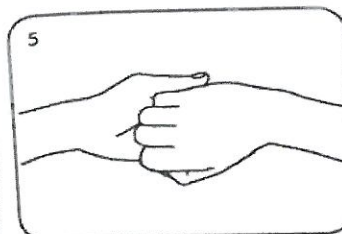
rub hands palm to palm



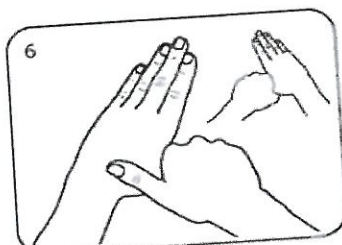
right palm over left dorsum with interlaced fingers and vice versa



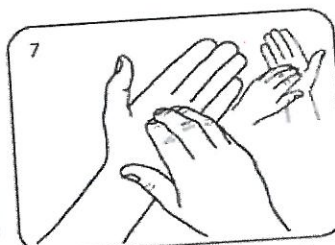
palm to palm with fingers interlaced



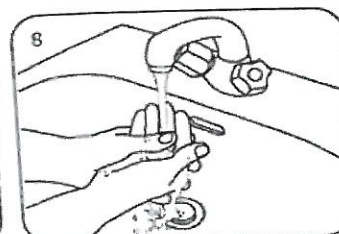
backs of fingers to opposing palms with fingers interlocked



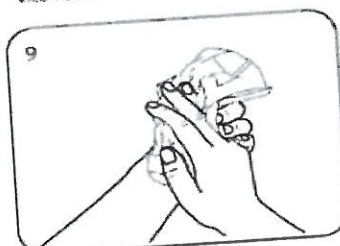
rotational rubbing of left thumb clasped in right palm and vice versa



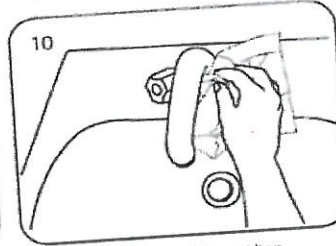
rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa



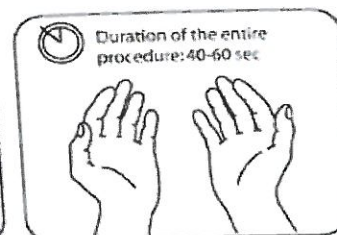
rinse hands with water



dry thoroughly with a single use towel



use towel to turn off faucet/tap



...and your hands are safe.

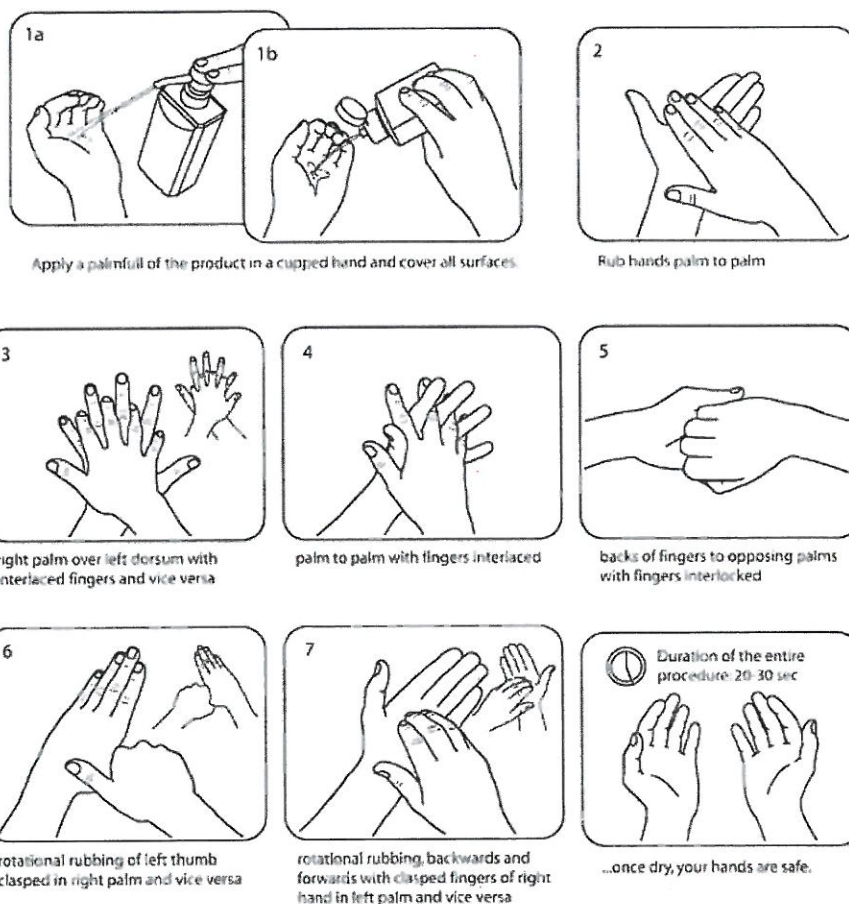
Modified according to EN1500

DEPARTMENT OF INFECTION PREVENTION AND CONTROL

APP VERSION:1	POLICY NUMBER:	APP: IPC-010	APPLIES TO: HOSPITAL WIDE
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Appendix IPC-10-2: Hand Rub Techniques

Hand Hygiene Technique with Alcohol-Based Formulation





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AL-Harth General Hospital

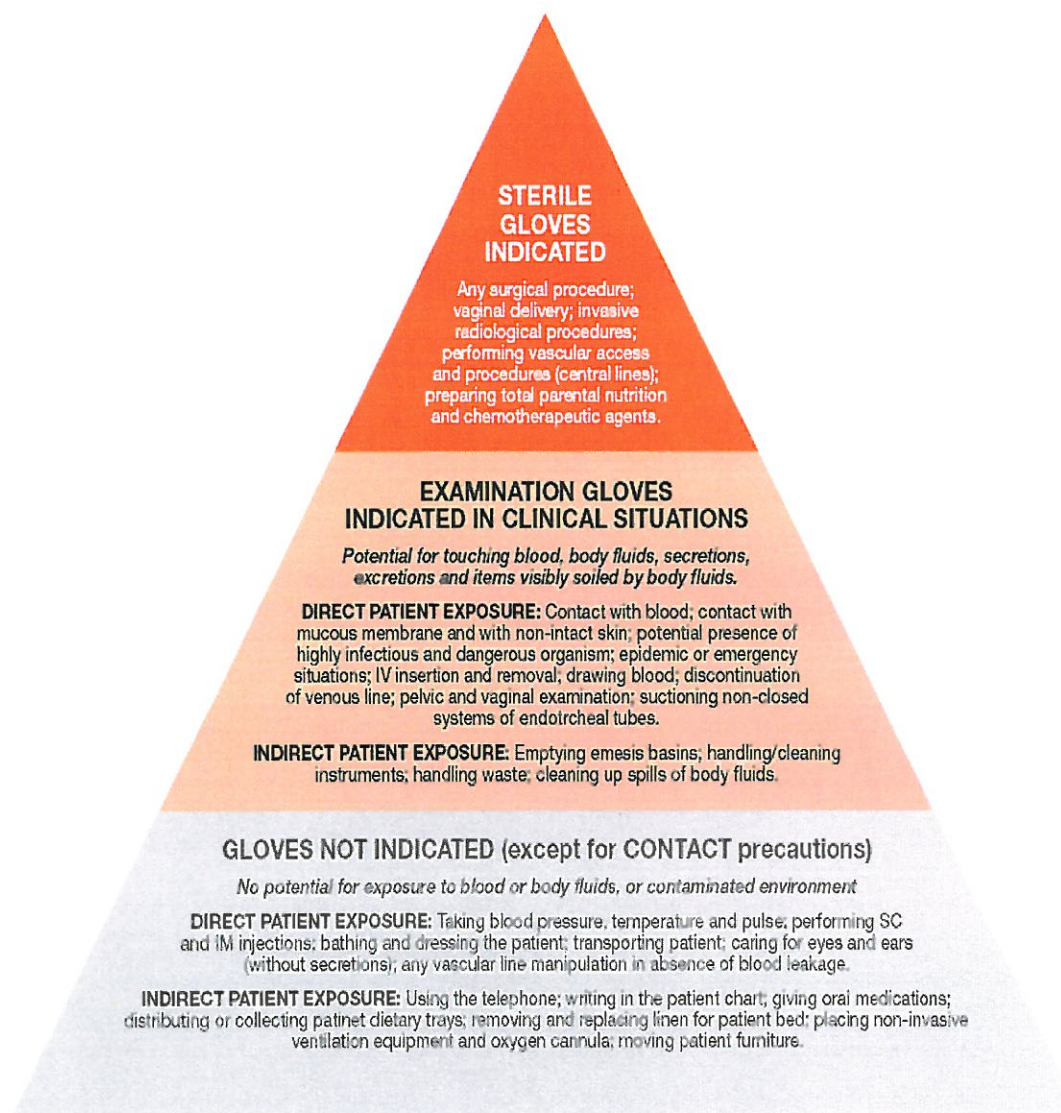


DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE

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Appendix IPC-10-3: Pyramid on Glove Use



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Appendix IPC-10-4: Surgical Hand Hygiene

The handrubbing technique for surgical hand preparation must be performed on perfectly clean, dry hands. On arrival in the operating theatre and after having donned theatre clothing (cap/hat/bonnet and mask), hands must be washed with soap and water. After the operation when removing gloves, hands must be rubbed with an alcohol-based formulation or washed with soap and water if any residual talc or biological fluids are present (e.g. the glove is punctured).

Surgical procedures may be carried out one after the other without the need for handwashing, provided that the handrubbing technique for surgical hand preparation is followed (Images 1 to 17).



1
Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your left hand, using the elbow of your other arm to operate the dispenser



2
Dip the fingertips of your right hand in the handrub to decontaminate under the nails (5 seconds)



3
Images 3–7: Smear the handrub on the right forearm up to the elbow. Ensure that the whole skin area is covered by using circular movements around the forearm until the handrub has fully evaporated (10-15 seconds)



4
See legend for Image 3



5
See legend for Image 3



6
See legend for Image 3



7
See legend for Image 3



8
Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your right hand, using the elbow of your other arm to operate the dispenser



9
Dip the fingertips of your left hand in the handrub to decontaminate under the nails (5 seconds)



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Appendix IPC-10-4:...cont.



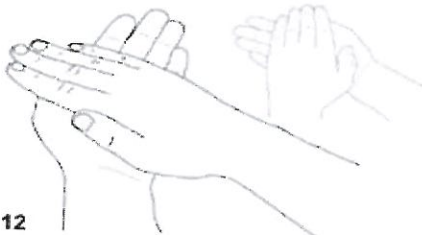
10

Smear the handrub on the left forearm up to the elbow. Ensure that the whole skin area is covered by using circular movements around the forearm until the handrub has fully evaporated (10-15 seconds)



11

Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your left hand, using the elbow of your other arm to operate the distributor. Rub both hands at the same time up to the wrists, and ensure that all the steps represented in Images 12-17 are followed (20-30 seconds)



12

Cover the whole surface of the hands up to the wrist with alcohol-based handrub, rubbing palm against palm with a rotating movement



13

Rub the back of the left hand, including the wrist, moving the right palm back and forth, and vice-versa



14

Rub palm against palm back and forth with fingers interlinked



15

Rub the back of the fingers by holding them in the palm of the other hand with a sideways back and forth movement



16

Rub the thumb of the left hand by rotating it in the clasped palm of the right hand and vice versa



17

When the hands are dry, sterile surgical clothing and gloves can be donned

Repeat the above-illustrated sequence (average duration, 60 sec) according to the number of times corresponding to the total duration recommended by the manufacturer for surgical hand preparation with an alcohol-based handrub.



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Appendix IPC-10-5: WHO Hand Hygiene Observation



World Health Organization

Patient Safety
A World Alliance for Better Health Care

SAVE LIVES
Clean Your Hands

Observation Form

Facility: _____ Date: (dd/mm/yy) ____/____/____ Session Number*: _____

Department: _____ Start/End time: (hh:mm) _____ Observer: (Initials) _____

bef-pat. Before contact patient			bef-asept. Before aseptic procedure			aft-b.f. After body fluid exposure			aft-pat. After contact patient			aft.p.surr. After contact pt surround		
Prof.cat	1. Nurse / Midwife	Prof.cat	2. Auxiliary	Prof.cat	3. Medical Doctor	Prof.cat	Other HCWs	Prof.cat	Other HCWs	Prof.cat	Other HCWs	Prof.cat	Other HCWs	
Opp.	Indication	HH Action	Opp.	Indication	HH Action	Opp.	Indication	HH Action	Opp.	Indication	HH Action	Opp.	Indication	HH Action
1	<input type="checkbox"/> bef-pat. <input type="checkbox"/> bef-asept. <input type="checkbox"/> aft-b.f. <input type="checkbox"/> aft-pat. <input type="checkbox"/> aft.p.surr.	<input type="checkbox"/> HR <input type="checkbox"/> HW <input type="radio"/> missed	1	<input type="checkbox"/> bef-pat. <input type="checkbox"/> bef-asept. <input type="checkbox"/> aft-b.f. <input type="checkbox"/> aft-pat. <input type="checkbox"/> aft.p.surr.	<input type="checkbox"/> HR <input type="checkbox"/> HW <input type="radio"/> missed	1	<input type="checkbox"/> bef-pat. <input type="checkbox"/> bef-asept. <input type="checkbox"/> aft-b.f. <input type="checkbox"/> aft-pat. <input type="checkbox"/> aft.p.surr.	<input type="checkbox"/> HR <input type="checkbox"/> HW <input type="radio"/> missed	1	<input type="checkbox"/> bef-pat. <input type="checkbox"/> bef-asept. <input type="checkbox"/> aft-b.f. <input type="checkbox"/> aft-pat. <input type="checkbox"/> aft.p.surr.	<input type="checkbox"/> HR <input type="checkbox"/> HW <input type="radio"/> missed	1	<input type="checkbox"/> bef-pat. <input type="checkbox"/> bef-asept. <input type="checkbox"/> aft-b.f. <input type="checkbox"/> aft-pat. <input type="checkbox"/> aft.p.surr.	<input type="checkbox"/> HR <input type="checkbox"/> HW <input type="radio"/> missed
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Opportunities No. _____			Opportunities No. _____			Opportunities No. _____			Opportunities No. _____			Opportunities No. _____		
Hand Wash No. _____			Hand Wash No. _____			Hand Wash No. _____			Hand Wash No. _____			Hand Wash No. _____		
Hand Rub No. _____			Hand Rub No. _____			Hand Rub No. _____			Hand Rub No. _____			Hand Rub No. _____		

* To be completed by the data manager.

** Optional, to be used if appropriate, according to the local needs and regulations.

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For more information, contact the World Health Organization, in particular the members of the Infection Control Programme, for their active participation in developing this material.



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	TITLE:	HAND HYGIENE	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:12 of 12

7. REFERENCES

- 7.1 GCC Manual for Infection Control 3rd Edition Manual(2018)
- 7.2 WHO Guidelines on Hand Hygiene in Healthcare 2009 (World Alliance for Patient Safety).

8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE			
APP VERSION:1	POLICY NUMBER:	APP: IPC-011	APPLIES TO: HOSPITAL WIDE
	TITLE:	PERSONAL PROTECTIVE EQUIPMENT (PPE)	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE :AGU 30,2020
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 7

1.0. PURPOSE:

- 1.1. To provide a set of guidelines for proper Personal Protective Equipment use by healthcare workers.

2.0. DEFINITION:

- 2.1. **Gloves** - a garment covering the whole hand. Gloves have separate sheaths or openings for each finger and the thumb. It protects hands.
- 2.2. **Goggles/Face shield** - are forms of protective eyewear that usually enclose or protect the eye area in order to prevent blood or body fluids from striking the eyes during patient procedure.
- 2.3. **Isolation gowns** - are made of fluid-resistant disposable material worn by healthcare workers during patient care procedures to protect against splashes or contamination or wearer's skin and personal clothing during patient contact.
- 2.4. **N95 respirator** - particulate respirator which is also known as "air-purifying respirators" because they protect by filtering particles out of the air you breathe. Healthcare workers can wear for protection against diseases spread through the air if they have been properly fit tested.
- 2.5. **Personal protective equipment (PPE)** - as defined by the Occupational Safety and Health Administration, or OSHA, is "specialized clothing or equipment, worn by an employee for protection against infectious materials." refers to a variety of barriers and respirators used alone or in combination to protect mucous membranes, airways, skin, and clothing from contact with infectious agents. The selection of PPE is based on the nature of the patient interaction and/or the likely mode(s) of transmission.
- 2.6. **Surgical mask** - is intended to be worn by healthcare workers during surgery and at other patient care procedures to catch the bacteria shed in liquid droplets and aerosols from the wearer's mouth and nose. It protects wearers from being splashed in the mouth with body fluids.

3.0. POLICY:

- 3.1. PPE is used in addition to normal clothing and uniforms to protect both the patient and Healthcare worker (HCW) from the potential risks of cross infection.
- 3.2. The type of protective equipment worn is based on the assessed risk of the



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

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	TITLE:	PERSONAL PROTECTIVE EQUIPMENT (PPE)	
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5.2.5.1. Before all patient contact.

5.2.5.2. Before all cleaning.

5.2.5.3. Before handling soiled linen and waste.

5.2.6. Remove gloves after contact with patients or lab specimens.

5.2.7. Do not wear gloves outside of the patient's room / anteroom.

5.2.8. Do not re-use gloves.

5.2.9. Donning Gloves

5.2.9.1. Use non-sterile for isolation.

5.2.9.2. Select according to hand size.

5.2.9.3. Insert hands into gloves.

5.2.9.4. Extend to cover wrist of isolation gown.

5.2.10. Removing Gloves

5.2.10.1. Do not touch outside of gloves.

5.2.10.2. Grasp outside of glove with opposite gloved hand; peel off turning gloves inside out.

5.2.10.3. Hold removed glove in gloved hand.

5.2.10.4. Slide fingers of ungloved hand under remaining glove at wrist.

5.2.10.5. Peel off from inside, creating a bag for both gloves.

5.2.10.6. Discard.

5.2.10.7. Gowns

5.3. Gowns

5.3.1. A new gown should be worn for every patient contact. Discard immediately if visibly contaminated.

5.3.2. The aim of wearing either a fluid repellent apron or gown is to:

5.3.2.1. Protect the healthcare workers clothing/ uniform from contamination with blood, body fluids, secretions and excretions.

5.3.2.2. Protect the patient from micro-organisms.

5.3.3. Always ensure:

5.3.3.1. The gown is worn correctly.

5.3.3.2. A full body, gown is worn when there is a risk of extensive splashing of blood, body fluids, secretions and excretions onto the skin of healthcare practitioners.



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clinical intervention to be undertaken. Uniforms and normal clothing are not considered to be personal protective equipment.

4.0. RESPONSIBILITY:

4.1. It is the responsibilities of all health care workers to follow proper donning and removing of PPE.

5.0. PROCEDURE:

5.1. Perform risk assessment

5.1.1. Assess risk of task

5.1.1.1. No blood/body fluid – No need to use PPE

5.1.1.2. Blood/body fluid and/or low risk of splashing – Use gloves, gowns.

5.1.1.3. Blood/body fluid and/or high risk of splashing – Use gloves, gowns, eye protection, surgical face mask, water proof gowns.

5.2. Gloves

5.2.1. Must be readily available, take account of the workers needs and fit well.

5.2.2. Are always a single use item.

5.2.3. The aim of wearing gloves is to:

5.2.3.1. Protect user's hands from becoming contaminated with blood, body fluids secretions and excretions

5.2.3.1. Protect user's hands from certain chemicals that may adversely affect the condition of the skin

5.2.3.2. Minimize risk of infection to patients.

5.2.4. Always ensure:

5.2.4.1. Hands are clean prior to putting gloves on.

5.2.4.2. Gloves fit correctly.

5.2.4.3. Types of gloves are suitable for the task to be undertaken.

5.2.4.4. Gloves are only used for one intervention/ procedure.

5.2.4.5. Gloves are disposed of in clinical waste bag.

5.2.4.6. Hand hygiene is performed following glove removal.

5.2.4.7. Gloved hands should never be washed or alcohol gel used.

5.2.5. Wear gloves:



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5.3.3.3. That aprons or gowns are worn as single use items for one procedure or episode of patient care.

5.3.3.4. That used apron/ gown is disposed of as clinical waste.

5.3.3.5. That hand hygiene is performed following removal and disposal of apron/ gown.

5.3.4. Donning Gown:

5.3.4.1. Gown is worn with the opening at the back.

5.3.4.2. Fully cover torso from neck to knees, arms to end of wrist, around the back.

5.3.4.3. Fasten in back at neck and waist.

5.3.5. Removing Gown:

5.3.5.1. Keep in mind that the front and sleeves of the gown are contaminated.

5.3.5.2. Unfasten neck, then waist ties.

5.3.5.3. Remove gown using a peeling motion; pull gown from each shoulder toward the same hand.

5.3.5.4. Gown will turn inside out.

5.3.5.5. Hold removed gown away from body, roll into a bundle and discard as medical waste.

5.4. Face masks

5.4.1. The aim of wearing a fluid repellent facemask is to protect the healthcare worker from potential exposure to blood, body fluids, secretions and excretions.

5.4.2. Always ensure:

5.4.2.1. The mask has a fluid repellent layer.

5.4.2.2. N95 particulate respirator should be used for patients in AIIR (Airborne Infection Isolation Room).

5.4.2.3. The mask is fitted and worn correctly.

5.4.2.4. The mask is worn for a single patient episode, and then disposed of.

5.4.2.5. The mask is removed correctly to minimize risk of contamination to hands.

5.4.2.6. The mask is disposed of as clinical waste.



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5.4.2.7. Hand hygiene is performed following removal and disposal of mask.

5.4.3. Donning Face Masks

5.4.3.1. Secure ties or elastic band at middle of head and neck

5.4.3.2. Fit flexible band to nose bridge

5.4.3.3. Fit snug to face and below chin

5.4.3.4. Fit-check respirator

5.4.3.5. N95 respirator should collapse upon inhalation

5.4.3.6. Check for leakage around face upon exhalation

5.4.4. Removing Face Masks

5.4.4.1. Do not touch front of mask or respirator

5.4.4.2. Grasp ONLY bottom then top ties/elastics and remove

5.4.4.3. Discard in waste container

5.5. Goggles

5.5.1. The aim of wearing goggles is to protect the eyes of the healthcare worker from contamination with:

5.5.1.1. Blood, body fluids, secretions and excretions

5.5.1.2. Chemicals

5.5.1.3.

5.5.2. Always ensure:

5.5.2.1. The goggles fits and is worn correctly.

5.5.2.2. The eye protection is removed with the minimum risk of contamination to the hands.

5.5.2.3. Goggles are used for one patient episode only.

5.5.2.4. That reusable goggles is cleaned with plain liquid soap and water then by wiping with 70% Isopropyl alcohol and if necessary disinfected by sending to CSSD for low temperature sterilization

5.5.2.5. That hand hygiene is performed following removal of eye protection.

5.5.3. Donning Goggles

5.5.3.1. Put on face and adjust to fit

5.5.4. Removing Goggles



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5.5.4.1. Do not touch outside goggles

5.5.4.2. To remove, handle by "clean" head band or ear pieces

5.5.4.3. Place in designated receptacle for reprocessing

5.6. Sequence for wearing and removing PPEs

5.6.1. Wearing PPEs

5.6.2. Gown

5.6.3. Mask or N95 respirator

5.6.4. Goggles/face shield

5.6.5. Gloves

5.7. Removing PPEs

5.7.1. Gloves

5.7.2. Goggles/face shield

5.7.3. Gowns

5.7.4. Mask or N95 respirator

6.0. EQUIPMENT/ATTACHMENT:

6.1. Plastic aprons

6.2. Sterile gloves (including latex free)

6.3. Non-sterile gloves (including latex free)

6.4. Eye protection (goggles)

6.5. Face protection (face shields)

6.6. Water impervious gowns

6.7. Isolation gowns

6.8. Surgical masks and N95 particulate respirators

6.9. Hand washing facilities/alcohol rub

6.10. Illustration on how to wear and remove PPE

7.0. REFERENCE:

7.1. GCC Manual for Infection Control 3rd Edition Manual(2018)



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ADMINISTRATIVE POLICY PROCEDURE			
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8.0.APPROVALS :

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		
Reviewed by:	Mr. Ali Neshili	IPC Director		
	Mr. Fahd Najmi	Nursing Director		
Concurred	Dr . Shougy Alhazmi	IPC committee chairman		
	Ms. Aisha khubrani	Quality Director		
Approved by:	Dr . Shougy Alhazmi	Medical Director		
	Mr. Khalid Al-Harthi	Hospital Director		





DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE			
IPP VERSION:2	POLICY NUMBER:	DPP: IPC-012	APPLIES TO: hospital wide
	TITLE:	HANDLING USED SHARPS AND DISPOSAL	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1.0. PURPOSE:

- 1.1. To ensure that the prevention of sharps is managed in such a way that all staff are using best practice to protect patients, staff, visitors and other stakeholders against risks of injury.
- 1.2. To identify the hazards and take action to eliminate or reduce them
- 1.3. To create an environment which minimizes the risk of a sharp's injury occurring.

2.0. DEFINITION:

- 2.1. **Safer Device** - is one that incorporates a built-in safety feature in its design, which is intended to reduce the risk of sharp or needlestick injury before, during or after its use. Devices that eliminate the unnecessary use of needles, and devices with safety features can reduce the number of sharps injuries incurred.

3.0. POLICY:

- 3.1. All staff has a duty to ensure sharps are managed and disposed of appropriately to avoid risk and potential injury.

4.0. RESPONSIBILITY:

- 4.1. It is the responsibility of the infection control department to monitor proper handling and disposal of sharps.

5.0. PROCEDURE:

5.1. Sharps disposal containers should be assembled and managed properly:

- 5.1.1. Always assemble sharps containers correctly. Press the lid down around the rim of the container and ensure you have heard the click of the lid as it snaps onto the bottom of the bin.
- 5.1.2. It is the responsibility of the person assembling the bin to complete the details on the label of the bin. This is to enable traceability of bins in case of an incident.
- 5.1.3. The appropriate size bin for the size and amount of sharps should be in use.



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- 5.1.4. Sharps bins should be wall mounted on brackets between waist and shoulder height. They should never be stored on the floor.
- 5.1.5. Sharps containers should never be overfilled. Bins should not be filled above the three quarters level.
- 5.1.6. All sharps bins must be labelled with the name of the unit and date when locked for disposal.
- 5.1.7. Sharps bins must never be disposed of in yellow clinical waste bags.
- 5.1.8. Used sharps bins awaiting collection for disposal must be kept in an area away from the public.
- 5.1.9. Staff transporting used sharps bins for disposal must wear heavy duty gloves.
- 5.1.10. Sharps bins awaiting removal by a contractor must be stored in a secure locked yellow bin dedicated for sharps waste only.

5.2. Practice safe use of sharp devices

- 5.2.1. Do not re-sheath needles after use. If this is essential (ie dental syringes) then a sheathing device must be used to manage this safely.
- 5.2.2. Use intravenous devices with a safety feature whenever possible.
- 5.2.3. Gloves should be used when performing venipuncture and intravenous therapy care.
- 5.2.4. Assistance should be sought to handle confused patients, babies or young children.
- 5.2.5. Sharps should never be passed from hand to hand.

5.3. Practice safe disposal of Sharps

- 5.3.1. All sharps should be disposed of immediately after use, at the point of care.
- 5.3.2. Sharps bins should be available at the point of use e.g. on drug and cardiac arrest trolleys.
- 5.3.3. Disposal of sharps is the responsibility of the person using them. This should never be delegated.
- 5.3.4. Syringes and needles should be discarded as a single unit. It is not appropriate to disconnect the needle from the syringe before disposal.
- 5.3.5. Only dispose of sharps in a sharps bin. Never dispose of sharps with other clinical waste.

5.4. In the event of spillage of sharps, proper management is recommended:



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5.4.1. Always wear gloves.

5.4.2. Use disposable tweezers to pick up the sharps, if they are not available wear two pairs of disposable gloves to pick up the sharps (remember that wearing two pairs of gloves does not exclude the risk of a sharps injury).

5.4.3. Dispose of sharps into another sharps bin.

5.4.4. Dispose of gloves and tweezers in clinical waste bag.

5.5. Use of safer devices is recommended. A safer device product must:

5.5.1. Provide a barrier between the hands and needle.

5.5.2. Allow and/or require workers hands to remain behind the needle at all times.

5.5.3. Have safety features that are an integral part of the device.

5.5.4. Have safety features that cannot be deactivated and remain protective throughout disposal to protect downstream workers.

5.5.5. Be simple and self-evident to operate and require little or no training for effective use.

5.5.6. Be appropriate to the procedure to be undertaken and should be chosen following a risk assessment.

5.6. Management of Needle Prick:

5.6.1. Encourage bleeding from the puncture wound by keeping it low.

5.6.2. Do not press the injured site.

5.6.3. Wash the site with soap and water.

5.6.4. Apply antiseptic on the puncture wound and cover with occlusive dressing.

6.0. MATERIAL/EQUIPMENT:

6.1. Sharp container

7.0. REFERENCE:

7.1. GCC Manual for Infection Control, 3rd Edition (2018)



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8.0. APPROVALS:

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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INTRDEPARTMENTAL POLICY PROCEDURE			
IPP VERSION:1	POLICY NUMBER:	IPP: IPC-013	APPLIES TO: Patient care units
	TITLE:	ASEPTIC TECHNIQUES	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1.0. PURPOSE:

- 1.1. To provide guidelines on practices to reduce the number of microorganisms on hands, supplies and equipment during patient care procedures.

2.0. DEFINITION:

- 2.1. **Aseptic technique** refers to practices designed to render and maintain objects and areas maximally free of microorganisms. This may consist of aid in the prevention of surgical site, urinary tract, bloodstream, and pneumonia infections that may be device or procedure related.
- 2.2. **Clean technique (medical asepsis)** refers to practices that reduce the number of microorganisms or prevent/reduce transmission from one person (or place) to another.
- 2.3. **Sterile technique (surgical asepsis)** refers to practices that provide the maximum reduction of skin microorganisms without damaging tissues. It involves the use of barrier techniques to decrease the transmission of microorganisms from personnel to patients.

3.0. POLICY:

- 3.1. All Healthcare workers must follow both sterile and clean techniques depend on the procedure to be done.

4.0. RESPONSIBILITY:

- 4.1. It is the responsibilities of all healthcare workers to follow aseptic techniques depending on the procedures.

5.0. PROCEDURE:

5.1. Clean technique (medical asepsis)

- 5.1.1. Use clean techniques for routine patient care procedures.
- 5.1.2. Prepare and organize equipment and supplies.
- 5.1.3. Reduce the number of skin microorganisms by adhering to proper hand hygiene practices.
- 5.1.4. Use clean or sterile single-use patient devices and equipment if available, or use reusable devices and equipment that have been properly cleaned and reprocessed.



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- 5.1.5. Select an appropriate site on patient (isolate the area)
 - 5.1.5.1. Prepare the patient's skin before the procedure by applying the hospital-approved antiseptic agent to the patient's clean skin.
 - 5.1.5.2. Use correct skin prep for the patient's body site.
 - 5.1.5.3. Clean from the area that is clean to the area that is dirty.
 - 5.1.5.4. Remove hair only when necessary; do so immediately before the procedure using clippers and NOT razors.
- 5.1.6. Use barrier techniques to reduce microbial transmission from patient to personnel.
 - 5.1.6.1. Use a "no-touch" dressing technique to avoid the contamination of sterile supplies. Use sterile gloves or forceps for the application of dressings.
 - 5.1.6.2. Wear a clean gown/apron to minimize the contamination of clothing.
 - 5.1.6.3. Wear clean gloves to avoid direct contact with infectious materials.
- 5.1.7. Provide environmental controls to reduce microbial transmission.
 - 5.1.7.1. Use negative-pressure rooms for patients with infectious agents that can be spread by airborne route.
 - 5.1.7.2. Change the covers/sheets used on examination table, stretchers, or wheelchairs) between patients.
- 5.2. **Sterile technique (surgical asepsis)**
 - 5.2.1. Use sterile techniques for all invasive procedures.
 - 5.2.2. Reduce the number of skin microorganisms by adhering to proper hand hygiene practices.
 - 5.2.3. Decontaminate your hands using an antiseptic hand rub (chlorhexidine/alcohol-based product) or antiseptic soap before putting on sterile gloves.
 - 5.2.4. Prepare and organize equipment and supplies.
 - 5.2.5. Use sterile, single-use patient devices and equipment.
 - 5.2.6. Select the appropriate site on the patient (isolate the area)
 - 5.2.6.1. Prepare the patient's skin before the procedure by applying the hospital-approved antiseptic agent to the patient's clean skin.
 - 5.2.6.2. Use the correct skin prep for the patient's body site.



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- 5.2.6.3. Clean from the area that is cleanest to the area that is dirty.
- 5.2.6.4. Remove hair only when necessary; do so immediately before the procedure using clippers and NOT razors.
- 5.2.7. Use barriers to decrease the transmission of microorganisms from personnel to the patient.
 - 5.2.7.1. Mask, sterile gown and gloves, head cover, and large sterile surgical drape on the patient should be used.
 - 5.2.7.2. Put on appropriate sterile apparel as required by risk of procedure to be performed.
 - 5.2.7.3. Maintain an area of sterility with the use of sterile supplies (e.g., gloves, drapes, and other equipment).
- 5.2.8. Provide environmental controls to maximize the reduction of microorganisms during procedure.
 - 5.2.8.1. Use special treatment rooms when indicated (e.g., in the OR or radiology).
 - 5.2.8.2. Maintain positive pressure in the room.
 - 5.2.8.2.1. **NB:** Use negative-pressure rooms for patients with infectious agents spread by the airborne route. Provide a higher rate of air exchanges through the ventilation system.
 - 5.2.8.3. Exclude visitors and unnecessary personnel.
 - 5.2.8.4. Keep doors closed during procedures or use other physical barriers such as screens to divert traffic.
 - 5.2.8.5. Avoid cleaning/maintenance activities in the area during the procedure.
- 5.3. **Maintain asepsis**
 - 5.3.1. It is important to be fully prepared before starting any procedure.
 - 5.3.2. Anticipate what is needed for the procedure.
 - 5.3.3. Supplies required may include but are not limited to the following:
 - 5.3.3.1. Clean trolley (tray)
 - 5.3.3.2. Supplies (PPE, gauze, site prepping solutions)
 - 5.3.3.3. Equipment (proper pack, size, type, amount)
 - 5.3.3.4. Accessible disposal unit
 - 5.3.3.5. Help (if required)
 - 5.3.4. Avoid leaving the room/bedside to get supplies.



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- 5.3.5. Follow the approved policy for the procedure being performed.
- 5.3.6. Change gloves (after removing old dressing and before applying clean dressing).

5.4. Other recommendations to maintain asepsis

- 5.4.1. Clean and disinfect environmental surfaces routinely after each procedure.
 - 5.4.1.1. Use clean equipment and supplies (mops, water, cleaning cloths).
 - 5.4.1.2. Use detergent to remove soil.
- 5.4.2. Clean up body fluid spillage using hospital-approved disinfectant.
- 5.4.3. Dispose of all contaminated materials and supplies appropriately to avoid contaminating HCWs, patients and environmental surfaces.
- 5.4.4. Reprocessing of reusable equipment and surgical instruments must be done by the designated department.
- 5.4.5. Use special equipment for ventilation (e.g., high-efficiency particulate air filters or laminar air flow) when feasible.

6.0. MATERIAL/EQUIPMENT:

- 6.1. Hand hygiene solution (alcohol/soap)
- 6.2. Clean trolley (tray)
- 6.3. Supplies (PPE, gauze, drapes, site prepping solutions, etc.)
- 6.4. Equipment (proper pack, size, type, amount, etc.)

7.0. REFERENCE:

- 7.1. GCC Manual for Infection Control 3rd Edition Manual(2018)



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INTRDEPARTMENTAL POLICY PROCEDURE			
IPP VERSION:1	POLICY NUMBER:	IPP: IPC-009	APPLIES TO: Patient care units
	TITLE:	ASEPTIC TECHNIQUES	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:5 of 5

8.0. APPROVALS:

	NAME	POSITION	SIGNATURE	DATE
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	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



Table 1 : Recommendations for HCWs Regarding Hand and Skin Preparation of Patient Skin (site) ON

Procedure	Example	Hand Hygiene	Gloves	Preparation of Patient's Skin	Comment
A. Medical Asepsis (Clean Procedures)					
Procedures in which instruments come in contact with intact mucous membranes	1. Bronchoscopy, gastrointestinal endoscopy, tracheal suction	Antibacterial soap and water or alcohol-based hand rub**	Clean	None is required	
	2. Peripheral intravenous insertion	Antibacterial soap and water or alcohol hand rub**	Clean	Hospital – approved antiseptics* should be used Select appropriately for the patient's site	
	3. Urinary tract catheterization	Antibacterial soap and water or alcohol hand rub**	Sterile	Hospital-approved antiseptics* and rinse with sterile water	DO NOT use alcohol-containing antiseptic
B. Surgical Asepsis (Sterile Procedures)					
1. Procedures in which instruments go through sterile tissue or fluid	1. CVL insertion - CVL wire insertion - Cardiac pacemaker insertion	Surgical hand scrub with antibacterial soap and water or Alcohol surgical hand scrub**	Sterile	Hospital-approved antiseptics* should be used.	"Defatting" agents do not appear to decrease infections and can cause skin irritation
	2. Arterial line insertion	Surgical hand scrub with antibacterial soap and water or Alcohol surgical hand scrub**	Sterile	Hospital-approved antiseptics* should be used.	Most epidemics of infection associated with arterial pressure monitoring devices appear to be caused by hospital-associated contamination of components external to the skin, such as transducer heads or domes; "endemic" IV-related blood-stream infections are frequently associated with skin flora.

*Antiseptics available are :

1. 2% aqueous chlorhexidine gluconate swabs (for CVC insertion in neonates <2 wks and <1500grams-avoid excessive skin exposure, remove excess CHG with sterile gauze & observe for skin reactions)
2. 2% chlorhexidine in 70% alcohol swabs
3. 10% Povidone iodine (swabs or liquid)
4. 70% alcohol (swabs or liquid)

** Hand Preparations available are :

1. Antibacterial soap
2. 62% - 70% alcohol-based hand rub
3. 2% chlorhexidine in 70% alcohol surgical hand scrub (according to the manufacturer's recommendations)

Procedure	Example	Hand Hygiene	Gloves	Preparation of Patient's Skin	Comment
B. Surgical Asepsis (Sterile Procedures)					
	3. Spinal tap Thoracentesis Abdominal paracentesis Bone marrow biopsy	Antibacterial soap and water or alcohol-based hand rub**	Sterile	Hospital-approved antiseptics* should be used.	
	4. Cystoscopy	Antibacterial soap and water or alcohol hand rub**		Hospital – approved antiseptics* and rinse with sterile water	DO NOT use alcohol-containing antiseptic
	5. Chest tub insertion Colposcopy Laparoscopy Peritoneal catheter insertion	Surgical hand scrub with antibacterial soap and water or Alcohol surgical hand scrub**	Sterile	Hospital-approved antiseptics* should be used If hair removal is considered necessary, clippers should be used immediately before the procedure	
II. Minor skin surgery	1. Skin biopsy Suturing of small cuts, lancing boils and mole removal 2. Circumcision	Surgical hand scrub with antibacterial soap and water or Alcohol surgical hand scrub**	Sterile	Hospital-approved antiseptics* should be used.	
III. Other procedures (Major and minor surgery) that enter tissue below the skin	1. Hysterectomy 2. Cholecystectomy 3. Herniorrhaphy	Surgical hand scrub with antibacterial soap and water or Alcohol surgical hand scrub**	Sterile	Antiseptic* should be used after the site has been scrubbed with detergent. If hair removal is considered necessary, clippers should be used immediately before the procedure.	Hand disinfection before surgical procedures that enter deep tissue is usually prolonged to ensure that all areas that harbor bacteria are adequately cleaned.

***Antiseptics available are :**

- 2% aqueous chlorhexidine gluconate swabs (for CVC insertion in neonates <2 wks and <1500grams-avoid excessive skin exposure, remove excess CHG with sterile gauze & observe for skin reactions)
- 2% chlorhexidine in 70% alcohol swabs
- 10% Povidone iodine (swabs or liquid)
- 70% alcohol (swabs or liquid)

**** Hand Preparations available are :**

- Antibacterial soap
- 62% - 70% alcohol-based hand rub
- 2% chlorhexidine in 70% alcohol surgical hand scrub (according to the manufacturer's recommendations)



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY PROCEDURE			
IPP VERSION:2	POLICY NUMBER:	APP: IPC-014	APPLIES TO: PT CARE AREAS
	TITLE:	NOTIFICATIONS OF REPORTABLE DISEASE	
	APPROVAL DATE:	JUL 30,2023	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 4

1.0. PURPOSE:

- 1.1. To provide guidelines for notifying communicable diseases to Ministry of Health.
- 1.2. To enumerate the diseases that can be notified to the Ministry of Health.
- 1.3. To identify which communicable diseases to be reported immediately, weekly and monthly to Ministry of Health.

2.0. DEFINITION:

2.1. N/A

3.0. POLICY:

- 3.1. It is required that all employees of ALHARRTH GENERAL HOSPITAL involved in the management of patient with or suspected communicable diseases to report to the Infection Control Department.
 - 3.1.1. All communicable diseases shall be reported as soon as they are identified to the local Preventive Unit of the Ministry of Health by the Infection Control Officer or Nurse.

4.0. RESPONSIBILITY:

- 4.1. It is the responsibility of the nursing department to inform DIPC if there are communicable diseases admitted in the hospital.
- 4.2. It is the responsibility of the Infection Control staff to make notes and monitor if proper precautions are follow by the HCWs.
- 4.3. It is the responsibility of the Preventive Medicine Department to send notifications to regional directorate or MOH

5.0. PROCEDURE:

5.1. REPORTABLE COMMUNICABLE DISEASES:

- 5.1.1. In accordance with policies of the Ministry of Health, all cases of reportable diseases are to be promptly reported to the Directorate of Health Affairs in Riyadh Region.



Kingdom of Saudi Arabia
Ministry of Health
Jazan Health Directorate
AL-Harth General Hospital



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY PROCEDURE			
IPP VERSION:2	POLICY NUMBER:	APP: IPC-014	APPLIES TO: PT CARE AREAS
	TITLE:	NOTIFICATIONS OF REPORTABLE DISEASE	
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8.0.APPROVALS:

	NAME	POSITION	SIGNATURE	DATE
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Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		18-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE			
IPP VERSION:2	POLICY NUMBER:	IPP: IPC-015	APPLIES TO: PT CARE AREAS
	TITLE:	Surveillance Of Healthcare Associated Infection	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1. PURPOSE

- 1.1 To provide guidelines in conducting infection control surveillance for Hospital Acquired Infections HAIs including SSI and CAUTI.
- 1.2 Surveillance can be used for the following purposes:
 - 1.2.1 To measure the incidence of healthcare associated infections (HAI) and organisms.
 - 1.2.2 To establish an endemic rates of HAI.
 - 1.2.3 To detect, investigate and control hospital clusters or outbreaks of HAI
 - 1.2.4 To monitor, evaluate, and implement the necessary preventive measures
 - 1.2.5 To work on reducing HAI using standard bundles.

2. DEFINITION

- 2.1 **Surveillance** : is an essential component of an effective infection prevention and control (IPC) program. Surveillance is a systematic method of ongoing collecting, of a given disease or event, followed by the dissemination of consolidating and analyzing data concerning the distribution and determinates that information to those who can improve the outcome.
- 2.2 **HAI** is defined as a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) which must be no evidence that the infection was present or incubating at the time of admission to the care setting.
 - 2.2.1 The following infections are not considered healthcare associated:
 - 2.2.1.1 Physician diagnosis cannot be accepted as evidence of an infection unless physician diagnosis is an element of the specific infection definition.
 - 2.2.1.2 Reactivation of a latent infections (e.g., herpes zoster [shingles], herpes simplex, syphilis, or tuberculosis).
 - 2.2.2 The following conditions are not infections:
 - 2.2.2.1 **Colonization**, which means the presence of microorganisms on skin, on mucous membranes in open wounds, or in excretions or secretions but are not causing adverse clinical signs or symptoms.
 - 2.2.2.2 **Inflammation** that results from tissue response to injury or stimulation by noninfectious agents, such as chemicals.
 - 2.2.3 Related criteria of HAI definition:
 - 2.2.3.1 **Date of HAI event**
 - It is the date the first element used to meet an NHSN site-specific infection criterion occurs for the first time within the seven-day infection window period.
 - 2.2.3.2 **Present on admission (POA)**
 - An infection is considered POA if the date of event of the NHSN site-specific infection criterion occur:
 - Two calendar days before day of admission.
 - First day of admission (day 1).
 - Day after admission (day 2).



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- Exceptions: SSI & MRSA bacteremia may occur after patient's discharge from facility and be present upon readmission.

2.2.3.3 Device removal and reinsertion

- If urinary catheter were removed and reinserted before a full calendar day without a device, then continue the day count.
- Therefore if the patient is without a device (urinary catheter) for at least one full calendar day (NOT to be read as 24 hours), then start a new day count.

2.2.3.4 Non-accepted organisms:

- Specific fungal pathogens typically causing community-associated infections cannot be used to meet any HAI definition: Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus & Pneumocystis.

3. POLICY

3.1 All Surveillance methodology provides reliable, useful data to guide infection control interventions and recommendations.

3.2 In AL-Harth General Hospital HAIs surveillance indicators is being done for:

3.2.1 Patient Safety modules:

3.2.1.1 Device-Associated Module

- Catheter-Associated Urinary Tract Infection (CAUTI) Event

3.2.1.2 Procedure-Associated Module

- Surgical Site Infection (SSI) Event.

3.2.1.3 Medication-Associated Module

- Antimicrobial Use and Resistance (AUR); Microbiology Option.

3.2.1.4 Bundles

- Urinary catheter bundle
- Surgical bundle.
- MDRO bundle.

4. RESPONSIBILITY

IPC TEAM

5. PROCEDURES

5.1 SURVEILLANCE METHODOLOGY

5.1.1 The Patient Safety surveillance modules require active, patient-based, prospective priority-directed surveillance (as defined below) of device/medication/procedure-associated infection events and their corresponding denominator data by a trained



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infection control professional (ICP)

Active surveillance:

- 5.1.1.1.1 Trained personnel, ICPs, vigorously look for HAI.
- 5.1.1.1.2 Information accumulated by using a variety of data sources within and beyond the nursing ward.

Patient-based

- 5.1.1.2.1 Count HAI, assess risk factors, and monitor patient care procedures and practices for adherence to infection control principles.
- 5.1.1.2.2 Requires ward rounds and discussion with caregivers.

Prospective surveillance

- 5.1.1.3.1 Monitor patients during their hospitalization.
- 5.1.1.3.2 For SSIs, also monitor during the post-discharge period.

Priority-directed (also called targeted, focused, or Surveillance by Objective)

- 5.1.1.4.1 Targeted event
 - 5.1.1.4.1.1 Surgical Site Infection Target Surveillance Is Cesarean Section.(Refer to appendix IPC-15-01 SSI form and Instructions).
 - 5.1.1.4.1.2 Catheter-Associated Urinary Tract Infection .(Refer to appendix IPC-15-02 CAUTI Form & Instructions).

5.1.2 Location of Surveillance:

5.1.2.1 The patient care area to which a patient is assigned while receiving care in the healthcare facility. The location of surveillance could be inpatient, outpatient, or both:

- 5.1.2.1.1 UTI are surveyed only in inpatients.
- 5.1.2.1.2 SSI and MDRO may be surveyed in both inpatients and outpatients.
- 5.1.2.1.3 AUR-microbiology should be surveyed in both inpatients and outpatients.
- 5.1.2.1.4 Urinary catheter bundles are surveyed in inpatients.
- 5.1.2.1.5 Surgical bundle is surveyed in inpatients and/or outpatients

5.2 SURVEILLANCE DATA COLLECTION

5.2.1 **NUMERATOR DATA** : is the upper portion of a fraction used to calculate a rate or ratio. In surveillance, it is usually the number of cases of a disease or event being studied.

5.2.1.1 **Numerator data to collect**

- 5.2.1.1.1 Demographic – name, date of birth, gender, hospital identification number, admission date.
- 5.2.1.1.2 Infection – onset date, site of infection, patient care location of HAI onset.
- 5.2.1.1.3 Risk factors – devices, procedures, other factors associated with HAI.
- 5.2.1.1.4 Laboratory – pathogens, antibiogram, serology, pathology.

5.2.1.2 **Sources of numerator data**

- 5.2.1.2.1 Admission/discharge/transfer records, microbiology laboratory



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records.

5.2.1.2.2 Visits to patient wards for observation and discussion with caregivers.

5.2.1.2.3 Patient charts (paper or computerized) for case confirmation:

Laboratory and radiology/imaging results.

Nursing and physician's notes and consults

History and physical examination findings.

Records of diagnostic and surgical interventions.

Temperature chart.

Information on administration of antibiotics

5.2.1.2.4 For post-discharge detected SSI, sources include records from surgery clinics, emergency departments.

5.2.1.3 **How an ICP collects numerator data:**

5.2.1.3.1 **By using Daily Tracking of Infections form (Refer to appendix IPC-15-3)**

5.2.1.3.2 Screens admission/discharge/transfer records for patients admitted with infection and those whose diagnoses put them at risk of acquiring HAI.

5.2.1.3.3 Reviews laboratory reports looking for patients with possible infections (e.g., positive microbiology cultures, positive pathology findings) and converses with laboratory personnel trying to identify patients that might be infected and to identify clusters of infections, especially in areas not targeted for routine HAI surveillance.

5.2.1.3.4 During ward rounds, quickly screens nursing care reports, temperature charts, antibiotic administration sheets and converses with nurses and physicians trying to identify patients who might be infected.

5.2.1.3.5 Performs chart review of patients suspected of having HAI: reviews physician's progress notes and nurse's notes, laboratory data, radiology/imaging reports, surgery reports, etc.

5.2.1.3.6 Completes HAI data collection forms/screens as data sources are reviewed.

5.2.2 **DENOMINATOR DATA** : is the lower portion of a fraction used to calculate a rate or ratio. Denominator data may be collected by someone other than the ICP as long as that person is trained. When denominator data are available from electronic databases (e.g., patient tracking systems, respiratory therapy database), these sources may be used as long as the counts are not substantially different (+/- 5%) from those collected manually.

5.2.2.1 **Denominator data to collect**

5.2.2.1.1 Device-associated UTI incidence density rates: record daily the total number of patients and total number of urinary catheter-days in the patient care area(s) under surveillance; sum these daily counts at the end of the surveillance period for use as denominators.

5.2.2.1.2 AUR-microbiology: record the number of tested isolates.



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INTERDEPARTMENTAL POLICY AND PROCEDURE

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5.2.2.1.3 SSI : record information on operative procedures selected for surveillance (**Cesarean Section**).

5.2.2.2 **Sources of denominator data**

5.2.2.2.1 Device-associated UTI incidence density rates: visits to patient care areas to obtain daily counts of the number of patients admitted and the number of patients with each of the commonly used devices associated with HAI.

5.2.2.2.2 AUR-microbiology: processing laboratory reports.

5.2.2.2.3 For SSI rates: detailed logs from the operating room for (**Cesarean Section**).

5.3 SURVEILLANCE DATA ANALYSIS

5.3.1 **Incidence and prevalence**

5.3.1.1 **Incidence rate**: a measure of the frequency with which an event occurs in a population over a defined time period. The numerator is the number of new cases occurring during the defined time period, and the denominator is the population at risk.

5.3.1.2 **Prevalence rate**: the proportion of persons in a population who have a particular disease or condition (new and previously existing) at a specified point in time or over a specified period of time.

5.3.1.3 Note: **Attack rate** is a type of incidence rate used to measure the frequency of new cases of a disease or condition in a specific population during a given (short) period of time; expressed as a percentage.

5.3.2 **CALCULATING RATES**

5.3.2.1 CAUTI: Rate per 1000 urinary catheter-days is calculated by dividing the number of CAUTIs by the number of catheter-days and multiplying the result by 1000. The Urinary Catheter Utilization Ratio is calculated by dividing the number of urinary catheter-days by the number of patient-days.

5.3.2.2 **AUR-microbiology**: Antimicrobial resistance data are expressed as prevalence resistance rates per 100 isolates tested (i.e., the number of resistant isolates divided by the number of isolates tested x 100).

5.3.2.3 **SSI**: The SSI rates per 100 operative procedures are calculated by dividing the number of SSIs by the number of specific operative procedures(**Cesarean Section**) and multiplying the results by 100.

5.3.2.4 **MDRO-Infection Surveillance**: MDRO infection incidence rate is calculated by dividing the number of infections of a certain MDRO type by the number of patient days and multiplying the results by 1000. Rate is then stratified by time (e.g., month, quarter, etc.) and patient care location.

5.3.3 **BENCHMARKING**

5.3.3.1 Benchmarking is the process of “comparing oneself to others performing similar activities, so as to continuously improve.



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE

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5.3.3.1.1 Internal benchmarking: Compare own rates from one month to another.

5.3.3.1.2 external benchmarking :

Compare rate to others hospital (AL-TWAL GENERAL HOSPITAL)

Compare rate to NHSN pool mean

5.4 SURVEILLANCE REPORTING

5.4.1 A written report should be developed to provide a mechanism to interpret and disseminate surveillance data to stimulate performance improvement activities. Tables, graphs, and charts are effective tools for organizing, summarizing, and visually displaying data and should be used as applicable.

5.4.1.1 Mechanism of reporting:

5.4.1.1.1 The following persons/departments need to receive a copy final report:

Infection control committee .

Hospital Director / Medical director

In-patient Department supervisor

5.4.1.1.1.4 Healthcare workers who have immediate concern with the report contents.

5.5 CASE DEFINITION

5.5.1 Device-associated infection-catheter-associated urinary tract infection (CAUTI) event: (Refer to policy IPC-16 CDC criteria of HAI)

5.5.2 Procedure-associated module -surgical site infection (SSI) event: (Refer to policy IPC-16 CDC criteria of HAI).

5.6 BUNDLES

5.6.1 **Urinary catheter bundle** :Urinary catheter bundle is a group of evidence-based interventions for patients with urinary catheter that, when implemented together, result in better outcomes (reduce UTI) than when implemented individually. They include:

5.6.1.1 Avoid unnecessary urinary catheters

5.6.1.2 Insert using aseptic technique

5.6.1.3 Maintain catheters based on recommended guidelines (daily care)

5.6.1.4 Review catheter necessity daily and remove promptly

5.6.2 **Surgical bundle** :The surgical bundle is a group of evidence-based interventions for patients undergoing surgery that, when implemented together, result in better outcomes (reduce SSI) than when implemented individually. They include:

5.6.2.1 Appropriate use of prophylactic antibiotics;

5.6.2.1.1 Selection

5.6.2.1.2 Timely administration



Kingdom of Saudi Arabia
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5.6.2.1.3 Timely discontinuation

5.6.2.2 Appropriate hair removal;

5.6.2.3 Controlled 6 AM postoperative serum glucose in cardiac surgery patients

5.6.2.4 Immediate postoperative normothermia (36.1-37.1 C°) for colorectal surgery patients.

5.6.3 MDRO bundle.

6. ATTACHMENT

6.1 APPENDIX **IPC-15-01** : SSI form and Instructions.

6.2 APPENDIX **IPC-15-02** :CAUTI Form & Instructions.

6.3 APPENDIX **IPC-15-03** : Daily Tracking of Infections form.

7. REFERENCES

7.1 GCC Healthcare Associated Infection (Surveillance Manual) 3rd Edition (2018).

8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
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Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE			
IPP VERSION:2	POLICY NUMBER:	IPP: IPC-016	APPLIES TO: PT CARE AREAS
	TITLE:	CDC Criteria Of Healthcare Associated Infection	
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1. PURPOSE :

- 1.1 To be able to identify healthcare associated infection in the hospital units.
- 1.2 To establish a standard guidelines regarding criteria on identifying healthcare associated infection (HAI).

2. DEFINITION

- 2.1 **CAUTI** is defined as a symptomatic urinary tract infection (SUTI) or asymptomatic bacteremia UTI (ABUTI) in a patient who had an indwelling urinary catheter.
- 2.2 **Indwelling urinary catheter** is defined as a drainage tube that is inserted into the urinary bladder through the urethra, is left in place, and is connected to a closed collection system; also called a Foley catheter; does not include straight in-and-out catheters.
- 2.3 **An NHSN operative procedure** is a procedure that takes place during an operation defined as a single trip to the operating room (OR) where a surgeon makes at least one incision through the skin or mucous membrane, including laparoscopic approach, and primarily closes the incision before the patient leaves.

3. RESPONSIBILITIES

- 3.1 This procedure is performed by Infection Control Team and all staff directly in contact or giving direct care to patients.

4. POLICY:

- 4.1 Education and enforcement of policies and procedures are essentials to prevent HAI in the hospital.

5. PROCEDURE:

5.1 Criteria based on CDC Definitions

5.1.1 **Device-associated infection-catheter-associated - urinary tract infection (CAUTI) event (Refer to appendix IPC-16-01 CAUTI CDC Criteria 2016)**

- 5.1.1.1 an infection in a patient with a device (urinary catheter) that was used at or was removed within 2 calendar days before onset of infection.
- 5.1.1.2 the date of device-associated hai event is the date the first element used to meet the infection criterion occurs for the first time within the seven-day



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infection window period.

5.1.1.3 if the device-associated hai develops within 2 calendar days of discharge from a location, it is associated with the discharging location.

5.1.1.4 indwelling urinary catheter has to be in place for >2 days and in place at the date of event or the day before.

5.1.2 **Procedure-associated module -surgical site infection (SSI) event (Refer to appendix IPC-16-02 SSI CDC Criteria 2016)**

5.1.2.1 infection occurs within 30 or 90 days (according to the operative procedures) after an operative procedure that involves the skin or subcutaneous tissue. (superficial incisional SSI), deep soft tissue (deep incisional SSI), or any other part of the body that is opened or manipulated during the operative procedure (organ/space SSI).

5.1.2.2 Use 90 days only for these NHSN operative procedure; BRST, CARD,CBGB, CBGC, CRAN, FUSN, FX, HER, HPRO, KPRO, PACE, PVBY, or VSHN

5.1.2.3 The following are details of the three types of SSI:

- **Superficial Incisional SSI** : Infection occurs within 30 days after any NHSN operative procedure, and infection involves only skin and subcutaneous tissue of the incision, and at least one of the following:
 - Purulent drainage from the superficial incision.
 - Organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture methods.
 - At least one of the following signs and symptoms of infection: pain or tenderness; localized swelling; erythema; or heat, **and** superficial incision is deliberately opened by surgeon, attending physician, or other designee and culture or non-culture based testing is not performed. Negative culture or non-culture testing does not meet this criterion.
 - Surgeon, attending physician, or other designee diagnosed a superficial incisional SSI.
- **Deep Incisional SSI** : Infection occurs within 30 or 90 days after the NHSN operative procedure, and infection involves deep soft tissue (e.g. fascial and muscle layers) of the incision, and at least one of the following:
 - Purulent drainage from the deep incision.
 - Patient has at least one of the following signs or symptoms: fever



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE			
IPP VERSION:2	POLICY NUMBER:	IPP: IPC-016	APPLIES TO: PT CARE AREAS
	TITLE:	CDC Criteria Of Healthcare Associated Infection	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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(>38°C); localized pain or tenderness, and deep incision that spontaneously dehisces, or is deliberately opened or aspirated and organism is identified by a culture or non-culture methods or culture or non-culture testing is not performed.

- Abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test.
- **Organ/Space SSI** : Infection occurs within 30 or 90 days after the NHSN operative procedure, and infection any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure, and at least one of the following:
 - Purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage).
 - Organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture methods.
 - Abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test AND meets at least one criterion for a specific organ/space infection site: for example IAB-Intraabdominal infection:
 - Organisms identified from purulent or abscess material.
 - Abscess without (a) or with (b) positive blood culture/non-culture for intestinal organisms.
 - Two of the following symptoms; fever, nausea, vomiting, abdominal pain, or jaundice AND (a) organism identified from the intraabdominal space or (b) positive blood culture/non-culture for intestinal organisms plus imaging suggestive of infection.

6. ATTACHMENT

- 6.1 Appendix IPC-16-1- CAUTI CDC Criteria 2016
- 6.2 Appendix IPC-16-2- SSI CDC Criteria 2016

7. REFERENCES:

- 7.1 CDC / NHSN Surveillance of HAI and Criteria for Specific Types of Infection in Acute Care Setting 2016
- 7.2 GCC (Surveillance HAI Manual) 3rd Edition (2018).



Kingdom of Saudi Arabia
Ministry of Health
Jazan Health Directorate
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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE			
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8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		
Reviewed by:	Mr. Ali Neshili	IPC Director		
	Mr. Fahd Najmi	Nursing Director		
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		
	Ms.Aisha Khubrani	Quality Director		
Approved by:	Dr. Shwagy Alhazmi	Medical Director		
	Mr. Khalid Al-Harthi	Hospital Director		



Daily Tracking of Infections

Hospital Name: _____

DATE : _____

Patient Name: _____

Gender: ☐ M ☐ F

Date of Admission: _____

MRN No.: _____

Date of Birth: ____/____/____(Y/M/D)

Diagnosis: _____

Infection Onset ____/____/____(Y/M/D)

Ward: _____

Treating Physician: _____

SITE OF INFECTION

RISK FACTORS (tick any that apply)

Urinary

- ☐ Symptomatic Urinary Tract Infection
☐ Catheter Related Infection (complete surveillance form for CAUTI)
☐ Other Specify: _____

- ☐ Foley Catheter ☐ Suprapubic Catheter ☐ Intermittent Catheter

Surgical Wound

- ☐ Surgical Site Infection (complete surveillance form for SSI)

- ☐ Wound Care ☐ Drain Tube
☐ Wound Care Product ☐ Whirlpool ☐ Adhesives

Respiratory

- ☐ Respiratory Tract - Common Cold/ Pharyngitis
☐ Influenza-like illness
☐ Pneumonia
☐ Other Lower Respiratory Tract Infection (Bronchitis, Tracheobronchitis)
Specify: _____

- ☐ Tracheostomy ☐ Croup Tent
☐ Inhaler Treatments ☐ Humidifier ☐ Ventilator

Gastrointestinal

- ☐ Gastroenteritis
☐ Other Specify: _____

- ☐ PEG tube ☐ NG tube ☐ OG tube

Bloodstream/IV

- ☐ Septicemia

- ☐ Peripheral Line ☐ Central Line ☐ Midline
☐ Injections ☐ Venipuncture

Eye, Ear, Nose and Mouth Infection

- ☐ Conjunctivitis
☐ Ear Infection

- ☐ Redness ☐ Pus x 24 hours

Skin/Soft Tissue

- ☐ Fungal skin infection
☐ Herpes simplex
☐ Herpes zoster
☐ Other Specify: _____

- ☐ Braces ☐ Wound Care ☐ Fever or Cold
☐ Immobilizer ☐ indwelling tube ☐ assistive device

Other infections (e.g. MDROs)

- ☐ Other Specify: _____

- ☐ Diabetes ☐ Medication (e.g. Chemotherapy, Steroids) ☐ Immunocompromised state

Culture Result: _____ Chest X-Ray: _____ Physician Diagnosis: _____

Antibiotic Ordered: _____ Signs & Symptoms: _____

Type of infection: ☐ Infectious ☐ Communicable ☐ Non Communicable
☐ Hospital Acquired Infection ☐ Community Acquired Infection

Type of precautions required (in addition to Standard Precautions): ☐ Contact ☐ Droplet ☐ Airborne

Name of person completing the form: _____

Date: _____

JAZAN HEALTH
AL-Harth General Hospital
Denominators for IN-PATIENT*
Infection Control Surveillance Form

Surveillance plan date

M M Y Y

Facility ID

S # #

Location: IN-PATIENT *

Location name:

Date	Number of patients	Number of patients with a urinary catheter
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		
Total		
Patient-days		Urinary catheter-days

*This form is good for ICU and other locations in the institution where patients are housed overnight (e.g., surgical wards). Not for neonatal intensive care units (NICU) or specialty care areas (SCA) (includes hematology/oncology wards, bone marrow transplant units, solid organ transplant units, inpatient dialysis units, and chronic care units).

Assurance of Confidentiality: The information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with applicable regulations

APPENDIX IPC16-01 CAUTI CDC CASE DEFINITION 2016

Catheter-associated UTI (CAUTI): UTI in a patient with an indwelling urinary catheter provided that all of the following hold on

- ☐ The catheter has been for >2 calendar days and was in place at the date of event or the day before
- ☐ Urine culture with no more than two species of organisms identified, at least one of which is a bacterium of $\geq 10^5$ CFU
- ☐ Signs & Symptoms:

Criterion 1A:

Patient has at least one of the following signs or symptoms:

- ☐ fever ($>38.0^{\circ}\text{C}$)
- ☐ suprapubic tenderness*
- ☐ costovertebral angle pain or tenderness*
- ☐ urinary urgency \neq
- ☐ urinary frequency \neq
- ☐ dysuria \neq

* With no other recognized cause

\neq These symptoms cannot be used when catheter is in place

Criterion 2:

Patient ≤ 1 year of age and has at least one of the following signs or symptoms:

- ☐ fever ($>38.0^{\circ}\text{C}$)
- ☐ hypothermia ($<36.0^{\circ}\text{C}$)
- ☐ apnea*
- ☐ bradycardia*
- ☐ lethargy*
- ☐ vomiting*
- ☐ suprapubic tenderness*

* With no other recognized cause

Asymptomatic Bacteremic UTI (ABUTI):

Patient has no signs or symptoms of SUTI 1A or 2 according to age:

- ☐ Patient has an organism* identified from blood specimen (using culture or non-culture methods) with at least one matching bacterium to the bacterium identified in the urine specimen.

* Bacterium only including commensals but cannot be candida or fungi alone

**Identifying Symptomatic Urinary Tract Infections (SUTI) &
Asymptomatic Bacteremic Urinary Tract Infections (ABUTI)**

Positive urine culture with no more than 2 species of organisms, at least one of which is a bacterium of $\geq 10^5$ CFU/ml.
All elements of the UTI criterion must occur during the Infection Window Period (Note: if none of the organisms present at $\geq 10^5$ cfu/ml are bacteria, answer = No)

No

Does not
meet UTI
criteria

Yes

Had an indwelling urinary catheter that had been in place for > 2 days,
AND was either:
1. Still present for any portion of the calendar day on date of event
OR
2. Removed day before date of event?

No

Yes

At least one of the following signs or symptoms?

- suprapubic tenderness*
- costovertebral angle pain*
- urgency^
- frequency^
- dysuria^
- fever ($> 38.0^{\circ}\text{C}$) –In a patient that is ≤ 65 years of age

* With no other recognized cause

^ These symptoms cannot be used when catheter is in place.

Yes

Meets
criteria for
non-catheter
associated
SUTI

No

Organism identified* from blood
specimen with at least one matching
bacterium to bacterium in the urine at
 $\geq 100,000$ cfu/ml?

* identified from by a culture or non-culture
based microbiologic testing method which is
performed for purposes of clinical diagnosis or
treatment (e.g., not Active Surveillance
Culture/Testing (ASC/AST)).

Yes

Meets criteria for
non-catheter
associated ABUTI

No

Does not meet
UTI criteria

Meets criteria for
catheter-
associated SUTI
(CAUTI)

At least one of the following signs or symptoms?

- a. Any age patient: fever ($> 38.0^{\circ}\text{C}$), suprapubic tenderness*, costovertebral angle pain*, urgency^, dysuria^, frequency^
- b. Patients ≤ 1 year of age: fever ($> 38.0^{\circ}\text{C}$), hypothermia ($< 36.0^{\circ}\text{C}$), suprapubic tenderness*, costovertebral angle pain*, apnea*, bradycardia*, lethargy*, or vomiting*

* With no other recognized cause

^ These symptoms cannot be used when catheter is in place.

Yes

No

Organism identified* from blood
specimen with at least one matching
bacterium to bacterium in the urine at
 $\geq 100,000$ cfu/ml?

* identified from by a culture or non-culture based
microbiologic testing method which is performed
for purposes of clinical diagnosis or treatment (e.g.,
not Active Surveillance Culture/Testing (ASC/AST)).

Yes

No

Meets criteria
for catheter-
associated
ABUTI (CAUTI)

Does not meet UTI
criteria

JAZAN HEALTH
AL-Harth General Hospital
Surgical Site Infection (SSI)
Infection Control Surveillance Form



SECTION I: PATIENT AND HOSPITAL INFORMATION

Patient ID:	<input type="text"/>	Date of birth:	<input type="text"/>	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Surveillance plan date:	<input type="text"/>	Facility ID:	<input type="text"/>	Procedure location:	<input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Both
		Ward/Unit:	<input type="text"/>		

SECTION II: OPERATIVE PROCEDURE INFORMATION
NHSN procedure name & code:

Pre-procedure diagnosis:

Multiple procedures:

- ☐ Yes, specify:
☐ No
☐ N/A

Emergency:

- ☐ Yes
☐ No

Trauma:

- ☐ Yes
☐ No

General anesthesia:

- ☐ Yes
☐ No

Diabetes:

- ☐ Yes
☐ No

Ht (cm): -----

Wt (kg): -----

Infection present at the time of surgery (PATOS):

- ☐ Yes
☐ No

Laparoscope/endoscope/scope:

- ☐ Yes
☐ No

Wound class:

- ☐ Clean
☐ II- Clean-Contaminated
☐ III-Contaminated
☐ IV-Dirty or infected

ASA score:

Actual procedure duration (min):

Proc duration cut-point (min):

Admission date

Discharge date

Date of procedure

Operative surgeon ID

SECTION III: PATIENT RISK INDEX CATEGORY

ASA score

Add 1 if ASA score was 3, 4, 5, otherwise 0

Wound class

Add 1 if the wound class was III or IV, otherwise 0

Procedure duration

Add 1 if the procedure duration exceeds the operation specific cut point, otherwise 0

Total

Risk index category of 0, 1, 2 or 3

SECTION IV: SSI EVENT INFORMATION
SSI diagnosed:

- ☐ Yes, complete below
☐ No

SSI Category: (See the back)

- ☐ Superficial incisional primary (SIP)
☐ Superficial incisional secondary (SIS)
☐ Deep incisional primary (DIP)
☐ Deep incisional secondary (DIS)
☐ Organ / Space, specify:

SSI detected:

- ☐ Before discharge
☐ After discharge
☐ On readmission

SSI date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y

Post-procedure BSI:

- ☐ Yes
☐ No

Hospitalization death:

- ☐ Yes, complete below
☐ No

Death date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y

SSI contributed to death:

- ☐ Yes
☐ No

Procedure-specific additional questions:

CSEC:

Labor duration-----hours

FUSN

Spinal Level:

- ☐ Atlas-axis ☐ Atlas-axis/Cervical
☐ Cervical ☐ Cervical/Dorsal/Dorsolumbar
☐ Dorsal/Dorsolumbar ☐ Lumbar/Lumbosacral

Approach/Technique:

- ☐ Anterior ☐ Posterior
☐ Anterior and Posterior ☐ Transoral

HPRO/KPRO

Type-1: ☐ Total ☐ Partial ☐ Resurfacing
Type-1: ☐ Primary ☐ Revision

SECTION V: LABORATORY RECORD

Time of specimen collection
----- AM / PM

Organism identified:

- ☐ Yes, complete the back
☐ No

COMMENTS:

	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	D	D	M	M	Y

Date data collected

Collector ID

Date data entered

Data entry ID

Data entry stamp

APPENDIX IPC16-02 SSI CDC CASE DEFINITION 2016

Criterion	Surgical Site Infection (SSI)
	<p>Superficial incisional SSI</p> <p>Must meet the following criteria:</p>
	<p>Infection occurs within 30 days after any operative procedure (where day 1 = the procedure date).</p> <p>AND</p> <p>Involves only skin and subcutaneous tissue of the incision</p> <p>AND</p> <p>Patient has at least one of the following:</p> <ol style="list-style-type: none"> Purulent drainage from the superficial incision. Organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment. Superficial incision that is deliberately opened by a surgeon, attending physician or other designee and culture or non-culture based testing is not performed. <p>AND</p> <p>Patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture based test that has a negative finding does not meet this criterion.</p> <p>d. Diagnosis of a superficial incisional SSI by the surgeon or attending physician or other designee.</p>
Comments	<p>There are two specific types of superficial incisional SSIs:</p> <ol style="list-style-type: none"> Superficial Incisional Primary (SIP) – a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for coronary artery bypass graft CBGB). Superficial Incisional Secondary (SIS) – a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)
Reporting Instructions for Superficial SSI	<p>The following do not qualify as criteria for meeting the definition of superficial SSI:</p> <ul style="list-style-type: none"> Diagnosis/treatment of cellulitis (redness/warmth/swelling), by itself, does not meet criterion for superficial incisional SSI. An incision that is draining or that has organisms identified by culture or non-culture based testing is not considered a cellulitis. A stitch abscess alone (minimal inflammation and discharge confined to the points of suture penetration). A localized stab wound or pin site infection. While it would be considered either a skin (SKIN) or soft tissue (ST) infection, depending on its depth, it is not reportable under this module. Circumcision: An infected circumcision site in newborns is not reportable under this module. An infected burn wound is classified as BURN and is not reportable under this module.
	<p>Deep incisional SSI</p> <p>Must meet the following criteria:</p> <p>Infection occurs within 30 or 90 days after the operative procedure (where day 1 = the procedure date).</p> <p>AND</p> <p>Involves deep soft tissues of the incision (e.g., fascial and muscle layers).</p> <p>AND</p> <p>Patient has at least one of the following:</p> <ol style="list-style-type: none"> Purulent drainage from the deep incision. A deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment. <p>AND</p> <p>Patient has at least one of the following signs or symptoms: fever ($\geq 38^{\circ}\text{C}$); localized pain or tenderness. A culture or non-culture based test that has a negative</p>

	<p>finding does not meet this criterion.</p> <p>c. An abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test.</p>
Comments	<p>There are two specific types of deep incisional SSIs:</p> <ol style="list-style-type: none"> 1. Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB). 2. Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB). <p>Organ/Space SSI</p> <p>Must meet the following criteria:</p> <p>Infection occurs within 30 or 90 days after the operative procedure (where day 1 = the procedure date.</p> <p>AND</p> <p>Infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure.</p> <p>AND</p> <p>Patient has at least one of the following:</p> <ol style="list-style-type: none"> a. Purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage). b. Organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is Performed for purposes of clinical diagnosis or treatment. c. An abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathology exam, or imaging test. <p>AND</p> <p>Meets at least one criterion for a specific organ/space infection site.</p>



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE			
IPP VERSION:2	POLICY NUMBER:	IPP: IPC-017	APPLIES TO: PT CARE AREAS
	TITLE:	PREVENTION OF URINE TRACT INFECTION	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 3

1. PURPOSE:

- 1.1. To provide policies for catheter care.

2. POLICY:

- 2.1. Urinary catheterization provides a potential entry for microorganisms and needs a set standard of guidelines for management.
- 2.2. Standard Precautions must be followed for all direct patient care, **refer to policy IPC 009 Standard precautions.**
- 2.3. CAUTI bundle must be followed daily by nursing staff for all patient with urine catheter and infection control practitioners check the compliance and validate the data (at least once week). **refer to policy IPC 17-01 CAUTI bundle form.**
- 2.4. Data of patients care bundle are regularly reported to infection control committee (quarter).

3. RESPONSIBILITY:

- 3.1. It is the responsibility of all HCWs to follow standard precautions for all direct patients' care.

4. PROCEDURE:

- 4.1. **Assess the need for catheterization**
- 4.1.1. Indwelling urinary catheters should be used only after alternative methods of management have been considered.
- 4.1.2. Review the patient's clinical need for catheterization every catheter change.
- 4.1.3. Remove catheter as soon as possible.
- 4.2. **Catheter insertion**
- 4.2.1. **Used Urinary Catheter Insertion Procedure Form IPC17-02**
- 4.2.2. All catheterizations carried out by healthcare personnel should be aseptic procedures and gloves must be worn.
- 4.2.3. Intermittent catheterization should be used in preference to an indwelling catheter if it is clinically appropriate and a practical option for the patient.



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE			
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- 4.2.4. For urethral and suprapubic catheters, the choice of catheter material will depend on an assessment of the patient's individual characteristics and predisposition to blockage.
- 4.2.5. For urethral catheterization, the meatus should be cleaned before insertion of the catheter with an antiseptic.
- 4.2.6. An appropriate lubricant/anaesthetic gel from a single-use container should be used during catheter insertion to minimize urethral trauma and infection.
- 4.2.7. The catheter balloon should be inflated with sterile water according to the manufacturer's guidelines. A 10ml balloon is advocated for adults and 3-5ml balloons for children.

4.3. Catheter drainage options

- 4.3.1. Indwelling catheters should be connected to a sterile closed urinary drainage system or catheter valve.
- 4.3.2. Healthcare personnel should ensure that the connection between the catheter and the urinary drainage system is not broken except for good clinical reasons e.g. changing the bag
- 4.3.3. Urinary drainage bags should be emptied frequently enough to maintain urine flow and prevent reflux, usually when two thirds full, or according to manufacturers' instructions.
- 4.3.4. Urinary drainage bags should normally be positioned below the level of the bladder.

4.4. Catheter maintenance

- 4.4.1. HCWs must perform hand hygiene and wear a new pair of clean, non-sterile gloves before handling a patient's catheter, and must wash their hands after removing gloves.
- 4.4.2. Urine samples must be obtained from a sampling port using an aseptic technique.
- 4.4.3. The meatus should be washed daily with soap and water or antiseptic.

5. MATERIAL/EQUIPMENT:

- 5.1. Urinary catheters
- 5.2. Urine bag
- 5.3. PPE
- 5.4. Antiseptic solutions
- 5.5. Supplies (syringe, lubricant, sterile water, etc.)
- 5.6. CAUTI Bundle Form IPC-17-01



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Jazan Health Directorate
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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE			
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	TITLE:	PREVENTION OF URINE TRACT INFECTION	
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5.7. Urinary Catheter Insertion Procedure Form IPC17-02

6. REFERENCE:

- 6.1. Medical Devices Agency (2000) Equipped to Care London, MDA
- 6.2. NHS Manchester (2003) Community Infection Control Guidelines
- 6.3. GCC 3rd Edition (2018).

7. APPROVALS :

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





Kingdom of Saudi Arabia
Ministry of Health
Jazan Health Directorate
AL-Harth General Hospital



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

A. PATIENT'S INFORMATION

Patient name:	MRN:	Unit:	Bed No.	Age:	M/F:
Admission date:	Admission diagnosis:				
IFC insertion date:	Place of Insertion:				
IFC removal date:					

B. URINARY CATHETER INSERTION BUNDLE

	Yes	No	Not Applicable
1. Avoid unnecessary urinary catheters			
2. Insert using aseptic technique: a. Hand hygiene before insertion of UC b. Use sterile equipment (Gloves, a drape, and sponges, Sterile or antiseptic solution for cleaning the urethral meatus and single-use packet of sterile lubricant for insertion) c. Use of small catheter as possible			



DEPARTMENT OF INFECTION PREVENTION AND CONTROL			
INTERDEPARTMENTAL POLICY AND PROCEDURE			
IPP VERSION:2	POLICY NUMBER:	IPP: IPC-018	APPLIES TO: PT CARE AREAS
	TITLE:	PREVENTION SURGICAL SITE INFECTION	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1. PURPOSE:

- 1.1. To provide policy to prevent surgical infection among patient with surgery.

2. DEFINITION :

- 2.1. A "bundle" is as a group of interventions related to a disease process that, when implemented together, result in better outcomes than when done individually. The components the bundle can be easily measured as "completed or not completed.
- 2.2. Surgical site infections (SSIs) are defined as infections: occurring up to 30 days after surgery, or up to one year after surgery in patients receiving implants. affecting either the incision or deep tissue at the operation site.
- 2.3. The surgical bundle is a group of evidenced – based interventions for patients undergoing surgery. When implemented together, these interventions result in better outcomes (reduce SSI) than when implemented individually.

3. RESPONSIBILITY

N/a

4. POLICY:

- 4.1. Surgical site infection bundle:
 - 4.1.1. Appropriate use of prophylactic antibiotics
 - 4.1.1.1. Selection.
 - 4.1.1.2. Timely administration.
 - 4.1.1.3. Timely discontinuation.
 - 4.1.2. Appropriate hair removal.
 - 4.1.3. Controlled 6AM postoperative serum glucose in cardiac surgery patients.
 - 4.1.4. Immediate postoperative normothermia (36.1–37.1°C) for colorectal surgery patients.
- 4.2. SSI – Wound Classification
 - 4.2.1. Class 1 = Clean
 - 4.2.2. Class 2 = Clean contaminated
 - 4.2.3. Class 3 = Contaminated
 - 4.2.4. Class 4 = Dirty infected



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE

IPP VERSION:2	POLICY NUMBER:	IPP: IPC-018	APPLIES TO: PT CARE AREAS
	TITLE:	PREVENTION SURGICAL SITE INFECTION	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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5. PROCEDURE:

5.1. Use attached form for Surgical Site Infection Bundle (SSI BUNDLE) Form IPC-18-1

5.2. Surgical Site Infection Bundle Form Instructions :

5.2.1. Bundle goal: Preventing SSIs by implementing four(4) well-documented components of care:

5.2.1.1. Appropriate Use of Prophylactic Antibiotics:

5.2.1.1.1. Antibiotics within 1 hour before surgical incision

5.2.1.1.2. Prophylactic antibiotic(s) is (are) consistent with the recently updated GCC guidelines for surgical prophylaxis.

5.2.1.1.3. Discontinuation of prophylactic antibiotics within 24 hours after surgery.

5.2.1.2. Appropriate Hair Removal:

5.2.1.2.1. The use of razors prior to surgery increases the incidence of wound infection (not acceptable) when compared to clipping, depilatory use, or no hair removal at all (acceptable). Any preoperative hair removal should not occur in the operating room itself because loose hairs are difficult to control.

5.2.1.2.2. Clipper machine available in female ward ext.143.

5.2.1.3. Maintenance of Post-Operative Glucose Control (for diabetics and cardiac patients only)

5.2.1.3.1. The degree of hyperglycemia in the postoperative period is correlated with the rate of SSIs in patients undergoing major cardiac surgery. Also, stringent glucose control in surgical intensive care unit patients reduces mortality.

5.2.1.4. Maintenance of Postoperative Normothermia(for all patients).

5.2.1.4.1. Preventing hypothermia is beneficial in reducing SSI in patients undergoing colorectal surgery and may be beneficial for other patients as well.

6. ATTACHMENT TOOLS :

6.1. Surgical site infection bundle checklist.

7. REFERENCE:



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Ministry of Health
Jazan Health Directorate
AL-Harth General Hospital



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7.1. GCC Healthcare Associated Infection (Surveillance Manual) 3rd Edition (2018).

8. APPROVALS :

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		
Reviewed by:	Mr. Ali Neshili	IPC Director		
	Mr. Fahd Najmi	Nursing Director		
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		
	Ms. Aisha Khubrani	Quality Director		
Approved by:	Dr. Shwagy Alhazmi	Medical Director		
	Mr. Khalid Al-Harthi	Hospital Director		



SURGICAL SITE INFECTION BUNDLE

NAME OF PATIENT		MEDICAL RECORD NUMBER	
DATE OF SURGERY:		CONSULTANT NAME:	
TYPE OF SURGERY:			
PREOPERATIVE PHASE	Yes	No	Comment
1. Screening & Decolonization for MRSA (for patients undergoing cardiac surgery)			
2. Preoperative bathe/shower with antiseptic soap or chlorhexidine			
3. Hair removal done If hair removal is needed, clipper was used			
4. Preoperative Antibiotic prophylaxis given Name of Antibiotic _____ dose _____ time _____ incision time _____			
5. Latest Vital signs checked: Time _____ BP _____ PR _____. Oral or axillary <ul style="list-style-type: none"> Temp before leaving ward or ER/Ward _____ Temp every 30 minutes intra-operatively _____ Temp every 15 minutes in the recovery area until a core temperature of 36.0°C is recorded _____ Temp every hour until it reaches normothermia (36.5°C) _____ Resp. _____ FHR _____ (if applicable)			
7. Diabetic Patient: blood glucose level: pre-op *Perioperative normoglycemia (on the day of surgery) glucose control @ 6AM maintain to <220mg/dl-11mmol/l			



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE			
APP VERSION:2	POLICY NUMBER:	APP: IPC-019	APPLIES TO: HOSPITAL WIDE
	TITLE:	ISOLATION PRECAUTIONS	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1.0. PURPOSE:

- 1.1. To describe the principles of isolation precautions (also known as expanded precautions) needed to further reduce or prevent the spread of epidemiologically significant or highly transmissible pathogens to, from and between patients, staff and visitors in the hospital when standard precautions alone are insufficient.

2.0. DEFINITION:

- 2.1. **Standard precautions** - are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals.
- 2.2. **Transmission-based precautions** - are designed for patients documented to be or suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are required.

3.0. POLICY:

- 3.1. Use Transmission-Based Precautions for patients with documented or suspected infection or colonization with highly transmissible or epidemiologically-important pathogens.
- 3.2. Extend duration of Transmission-Based Precautions, (e.g., Droplet, Contact) for immuno-suppressed patients with viral infections due to prolonged shedding of viral agents that may be transmitted to others.

4.0. RESPONSIBILITY:

- 4.1. It is the responsibility of all the staffs to follow the isolation precautions to any suspected or confirmed case of infectious diseases or transmissible pathogens.

5.0. PROCEDURE:

- 5.1. Nurses will take the following steps:
- 5.1.1. Initiate isolation precautions as specified and/or based on clinical



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assessment of the patient in consultation with the attending physician and/or infection control practitioner (ICP). (Microbiology reports may or may not support the clinical assessment.)

5.1.2. Arrange for the required isolation supplies for the room; place the appropriate isolation precautions sign on the room door and on the patient's Kardex.

5.1.3. Give the necessary instructions to patients and visitors.

5.2. CONTACT PRECAUTIONS

5.2.1. Use Contact Precautions for patients with known or suspected infections or evidence of syndromes that represent an increased risk for contact transmission.

5.2.2. Patient placement

5.2.2.1. Place patients in a single-patient room when available.

5.2.2.2. When single-patient rooms are in short supply, apply the following principles for making decisions on patient placement:

5.2.2.2.1. Prioritize patients with conditions that may facilitate transmission (e.g., uncontained drainage, stool incontinence) for single-patient room placement.

5.2.2.2.2. Place together in the same room (cohort) patients who are infected or colonized with the same pathogen and are suitable roommates.

5.2.2.3. If it becomes necessary to place a patient who requires Contact Precautions in a room with a patient who is not infected or colonized with the same infectious agent:

5.2.2.3.1. Avoid placing patients on Contact Precautions in the same room with patients who have conditions that may increase the risk of adverse outcome from infection or that may facilitate transmission (e.g., those who are immuno-compromised, have open wounds, or have anticipated prolonged lengths of stay).

5.2.2.3.2. Ensure that patients are physically separated (i.e., >3 feet apart) from each other. Draw the privacy curtain



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between beds to minimize opportunities for direct contact.).

5.2.2.3.3. Change protective attire and perform hand hygiene between contact with patients in the same room, regardless of whether one or both patients are on Contact Precautions

5.2.2.4. In *OPD*, place patients who require Contact Precautions in an examination room or cubicle as soon as possible.

5.2.3. **Use of Personal Protective Equipment (PPE)**

5.2.3.1. Gloves

5.2.3.1.1. Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g., medical equipment, bed rails).

5.2.3.1.2. Don gloves upon entry into the room or cubicle.

5.2.3.2. Gowns

5.2.3.2.1. Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient.

5.2.3.2.2. Don gown upon entry into the room or cubicle.

5.2.3.2.3. Remove gown and observe hand hygiene before leaving the patient-care environment.

5.2.3.2.4. After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental surfaces that could result in possible transfer of microorganism to other patients or environmental surfaces.

5.2.3.3. Please refer to **Personal Protective Equipment Policy**.

5.2.4. **Patient Transport**

5.2.4.1. Limit transport and movement of patients outside of the room to medically-necessary purposes.



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5.2.4.2. When transport or movement in any healthcare setting is necessary, ensure that infected or colonized areas of the patient's body are contained and covered.

5.2.4.3. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions.

5.2.4.4. Don clean PPE to handle the patient at the transport destination.

5.2.5. **Patient-care equipment and instruments/devices.**

5.2.5.1. Handle patient-care equipment and instruments/devices according to Standard Precautions.

5.2.5.2. Use disposable non-critical patient-care equipment (e.g., blood pressure cuffs) or implement patient-dedicated use of such equipment.

5.2.5.3. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient.

5.2.5.4. Please refer to the CONTACT PRECAUTIONS CARD.

5.3. **DROPLET PRECAUTIONS**

5.3.1. Use Droplet Precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets (i.e., large-particle droplets $>5\mu$ in size) that are generated by a patient who is coughing, sneezing or talking.

5.3.2. **Patient placement**

5.3.2.1. Place patients in a single-patient room when available.

5.3.2.2. When single-patient rooms are in short supply, apply the following principles for making decisions on patient placement.

5.3.2.2.1. Prioritize patients who have excessive cough and sputum production for single-patient room placement.

5.3.2.2.2. Place together in the same room (cohort) patients who are infected the same pathogen.

5.3.2.3. If it becomes necessary to place patients who require Droplet Precautions in a room with a patient who does not have the same infection.

5.3.2.4. Avoid placing patients on Droplet Precautions in the same room with patients who have conditions that may increase the risk of adverse outcome



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from infection or that may facilitate transmission (e.g., those who are immuno-compromised, have or have anticipated prolonged lengths of stay).

5.3.2.5. Ensure that patients are physically separated (i.e., >3 feet apart) from each other. Draw the privacy curtain between beds to minimize opportunities for close contact.

5.3.2.6. Change protective attire and perform hand hygiene between contact with patients in the same room, regardless of whether one patient or both patients are on droplet Precautions.

5.3.2.7. In *OPD*, place patients who require Droplet Precautions in an examination room or cubicle as soon as possible. Instruct patients to follow recommendations for Respiratory Hygiene/Cough Etiquette.

5.3.3. Use of personal protective equipment

5.3.3.1. Don a mask upon entry into the patient room or cubicle.

5.3.4. Patient transport

5.3.4.1. Limit transport and movement of patients outside of the room to medically-necessary purposes.

5.3.4.2. If transport or movement in any healthcare setting is necessary, instruct patient to wear a mask and follow Respiratory Hygiene/Cough Etiquette.

5.3.4.3. No mask is required for persons transporting patients on Droplet Precautions.

5.3.4.4. Discontinue Droplet Precautions after signs and symptoms have resolved or as per recommendations of the Infection Control.

5.3.4.5. Please refer to the DROPLET PRECAUTIONS CARD.

5.4. AIRBORNE PRECAUTIONS

5.4.1. Use Airborne Precautions for patients known or suspected to be infected with infectious agents transmitted person-to-person by the airborne route (e.g., *M tuberculosis*, Measles, Chickenpox, Disseminated herpes zoster).

5.4.2. Patient placement

5.4.2.1. Place patients who require Airborne Precautions in an Airborne Infection Isolation Room (AIIR) that has been constructed in accordance with current guidelines:

5.4.2.1.1. Provide at least six air changes per hour.



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5.4.2.1.2. Direct exhaust of air to the outside. If it is not possible to exhaust air from an AIIR directly to the outside, the air may be returned to the air-handling system or adjacent spaces if all air is directed through HEPA filters.

5.4.2.2. Keep the AIIR door closed when not required for entry and exit.

5.4.2.2.1. Consult infection control professionals before patient placement to determine the safety of alternative room that do not meet engineering requirements for an AIIR.

5.4.2.2.2. Place together (cohort) patients who are presumed to have the same infection(based on clinical presentation and diagnosis when known) in areas of the facility that are away from other patients, especially patients who are at increased risk for infection (e.g., immuno-compromised patients).

5.4.2.2.3. Use temporary portable solutions (e.g., exhaust fan) to create a negative pressure environment in the converted area of the facility. Discharge air directly to the outside, away from people and air intakes, or direct all the air through HEPA filters before it is introduced to other air spaces.

5.4.3. In OPD settings:

5.4.3.1. Place the patient in an AIIR as soon as possible. If an AIIR is not available, place a surgical mask on the patient and place him/her in an examination room. Once the patient leaves, the room should remain vacant for the appropriate time, generally one hour, to allow for a full exchange of air.

5.4.3.2. Instruct patients with a known or suspected airborne infection to wear a surgical mask and observe Respiratory Hygiene/Cough Etiquette. Once in an AIIR, the mask may be removed; the mask should remain on if the patient is not in an AIIR.

5.4.4. Personnel restrictions

5.4.4.1. Restrict susceptible healthcare personnel from entering the rooms of patients known or suspected to have measles (rubeola), varicella



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(chickenpox), disseminated zoster, or smallpox if other immune healthcare personnel are available.

5.4.5. Use of PPE

5.4.5.1. Wear a fit-tested NIOSH-approved N95 or higher level respirator for respiratory protection when entering the room of a patient on Airborne Precautions.

5.4.6. Patient transport

5.4.6.1. Limit transport and movement of patients outside of the room to medically-necessary purposes.

5.4.6.2. If transport or movement outside an AIIR is necessary, instruct patients to wear a surgical mask, if possible, and observe Respiratory Hygiene/Cough Etiquette.

5.4.6.3. For patients with skin lesions associated with varicella or smallpox or draining skin lesions caused by *M. tuberculosis*, cover the affected areas to prevent aerosolization or contact with the infectious agent in skin lesions.

5.4.6.4. Healthcare personnel transporting patients who are on Airborne Precautions do not need to wear a mask or respirator during transport if the patient is wearing a mask and infectious skin lesions are covered.

5.4.7. Please refer to the AIRBORNE PRECAUTIONS CARD.

6.0. MATERIAL/EQUIPMENT:

6.1. Isolation Precaution sign (Contact, Droplet, Airborne)

6.2. PPE

6.3. Hand hygiene (alcohol or soap)

7.0. REFERENCE:

7.1. GCC Manual for Infection Control 3rd Edition Manual(2018)

7.2. CDC website



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8.0. APPROVALS :

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		8-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr . Shougy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr . Shougy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





وزارة الصحة
Ministry of Health

الإدارة العامة لمكافحة العدوى
General Directorate for Infection Prevention and Control

TRANSPORTATION CARD

CONTACT PRECAUTIONS العزل التلامسي

- 1 > Notify the receiving unit/ward/department (Diagnosis, Type of Isolation Precautions).



إبلاغ القسم المستلم (التشخيص - نوع العزل).

- 2 > Prepare the patient for transportation :

- ◆ Dress wounds with impervious dressings.
- ◆ Dress the patient in a clean gown.
- ◆ Cover patient with clean sheet.
- ◆ HCW should wear clean gloves and perform hand hygiene after taking off .



- 3 > Staff should disinfect the patient's bed / wheeled chair using MOH approved disinfectant.



Use clean gloves

- 2 < يتم تحضير المريض للنقل كما يلي:

- ◆ تغطية جروح المريض بضماد غير منفذ للسوائل.
- ◆ إرتداء المريض لرداء طبي نظيف.
- ◆ تغطية المريض بملاءة نظيفة.
- ◆ يجب على الممارس الصحي إرتداء القفازات النظيفة ونزعها بعد الإنتهاء من نقل المريض وممارسة تطهير الأيدي.



- 3 < يجب على الممارس الصحي تطهير السرير/ الكرسي المشترك المستخدم لنقل المريض بعد النقل باستخدام المطهرات المعتمدة بوزارة الصحة.

TRANSPORTATION CARD

DROPLET PRECAUTIONS

العزل الرذاذي



1 > Notify the receiving unit/ward/department (Diagnosis, Type of Isolation Precautions).

2 > **Prepare the patient for transportation :**

- Patient should wear a surgical mask.
- Educate the patient about respiratory hygiene (Cough Etiquette).
- HCW should perform hand hygiene after patient transport.

3 > If the patient can not tolerate wearing a surgical mask, HCW should wear a surgical mask during transportation.

4 > Staff should disinfect the patient bed/ wheeled chair using MOH approved disinfectant.

1 < ابلاغ القسم المستلم (للتشخيص - نوع العزل).

2 < **يجب أن يتم تحضير المريض للنقل كما يلي:**

- أن يستخدم المريض الكمام الجراحي العادي أثناء نقله.
- تثقيف المريض عن العناية التنفسية (أداب السعال).
- يجب على الممارس الصحي ممارسة نظافة الأيدي بعد الانتهاء من نقل المريض.

3 < يجب على الممارس الصحي استخدام الكمام الجراحي العادي أثناء عملية النقل في حالة عدم إمكانية ارتداء المريض للكمام الجراحي الطبي العادي.

4 < يجب على الممارس الصحي تطهير السرير أو الكرسي المتحرك المستخدم لنقل المريض بعد النقل باستخدام المطهرات المعتمدة في وزارة الصحة.

Use surgical or medical masks

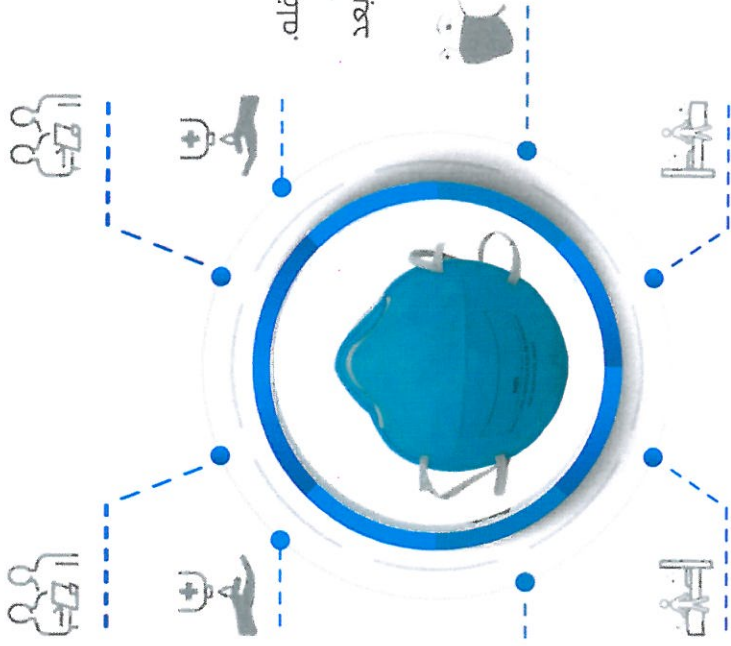


وزارة الصحة
Ministry of Health

الإدارة العامة للوقاية من الأمراض المعدية
General Directorate for Infectious Diseases Prevention and Control

TRANSPORTATION CARD

AIRBORNE PRECAUTIONS العزل الهوائي



Use N95 respirator

- 1 > Notify the receiving unit/ward/department (Diagnosis, Type of Isolation Precautions).

- 2 > Prepare the patient for transportation :

- Patient should wear surgical mask.
- Educate the patient about respiratory hygiene (Cough Etiquette).
- HCW should perform hand hygiene after patient transport.

- 3 > If the patient can not tolerate wearing a surgical mask, during transportation healthcare workers should wear the fitted N95 respirator.

- 4 > Staff should disinfect the patient bed/ wheeled chair using MOH approved disinfectant.

- 1 < إبلاغ القسم المستلم (التشخيص - نوع العزل).

- 2 < يجب أن يتم تحضير المريض للنقل كما يلي:

- أن يستخدم المريض الكمام الجراحي العادي أثناء نقله.
- تثقيف المريض عن العناية التنفسية (آداب السعال).
- يجب على الممارس الصحي ممارسة نظافة الأيدي بعد الانتهاء من نقل المريض.

- 3 < في حالة عدم إمكانية ارتداء المريض للكمام الجراحي الطبي العادي يجب على الممارس الصحي استخدام الكمام التنفسي عالي الكفاءة (N95) أثناء عملية النقل.

- 4 < يجب على الممارس الصحي تطهير السرير أو الكرسي المتحرك المستخدم لنقل المريض بعد النقل باستخدام المطهرات المعتمدة في وزارة الصحة.



وزارة الصحة
Ministry of Health

الإدارة العامة لمكافحة عدوى المنشآت الصحية
General Directorate for Infection Control of Health Facilities



إحتياطات العزل التلامسي CONTACT PRECAUTIONS

يجب على الزوار مراجعة مكتب التمريض قبل الزيارة
VISITORS : Report to nurse's station before entering the room

All HCWs and visitors
must do the following:

على جميع الممارسين
الصحيين و الزوار اتباع التالي:

before patient room or care
area entry :

- 1- Practice hand hygiene .
- 2- Wear isolation gown and gloves.

قبل دخول الغرفة او منطقة
المريض:

- 1- ممارسة نظافة الايدي.
- 2- ارتداء مريول العزل و القفازات .



before exit from patient room
or care area :

- 1- Remove gown and gloves and discard as medical waste.
- 2- Practice hand hygiene .

قبل الخروج من غرفة المريض أو
منطقة المريض:

- 1- يتم خلع مريول العزل والقفازات والتخلص منها في حاوية النفايات الطبية .
- 2- ممارسة نظافة الايدي.



وزارة الصحة
Ministry of Health

الإدارة العامة لمكافحة عدوى المنشآت الصحية
General Directorate for Infection Control of Health Facilities



احتياطات العزل الرذاذي DROPLET PRECAUTIONS

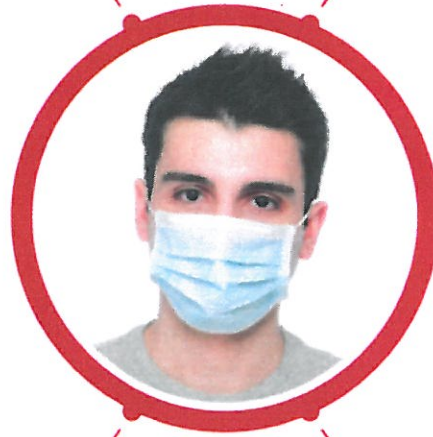
يجب على الزوار مراجعة مكتب التمريض قبل الزيارة
VISITORS : Report to nurse's station before entering the room

All HCWs and visitors
must do the following:

على جميع الممارسين
الصحيين و الزوار اتباع التالي:

**before patient room or care area
entry :**

- 1- Practice hand hygiene .
- 2- Wear a surgical Mask .



**قبل دخول الغرفة أو منطقة
المريض:**

- 1- ممارسة نظافة الأيدي.
- 2- ارتداء الكمام الجراحي العادي .

**before exit from patient room or
care area :**

- 1- Surgical Mask must be removed and discarded as medical waste.
- 2- Practice hand hygiene .

**قبل الخروج من غرفة المريض أو
منطقة المريض:**

- 1- يتم خلع الكمام الجراحي العادي والتخلص منه في حاوية النفايات الطبية .
- 2- ممارسة نظافة الأيدي.



احتياطات العزل الهوائي AIRBORNE PRECAUTIONS

يجب على الزوار مراجعة مكتب التمريض قبل الزيارة
VISITORS : Report to nurse's station before entering the room

All HCWs and visitors
must do the following:

Before patient room entry :

- 1- Practice hand hygiene .
- 2- Wear N95 respirator .

Before exit from patient room :

- 1- All personal protective equipment must be removed except N95 respirator and discarded as medical waste.

After exit from patient room :

- 1- Remove N95 respirator and discard as medical waste.
- 2- Practice hand hygiene .



على جميع الممارسين
الصحيين و الزوار اتباع التالي:

قبل دخول الغرفة :

- 1- ممارسة نظافة الايدي.
- 2- ارتداء الكمام التنفسي عالي الكفاءة .

قبل الخروج من غرفة المريض :

- 1- يتم خلع مستلزمات الوقاية الشخصية ماعدا الكمام التنفسي عالي الكفاءة والتخلص منها في حاوية النفايات الطبية .

بعد الخروج من غرفة المريض :

- 1- يتم خلع الكمام التنفسي عالي الكفاءة والتخلص منه في حاوية النفايات الطبية .
- 2- ممارسة نظافة الايدي.



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

DEPARTMENTAL POLICY PROCEDURE

DPP VERSION:2	POLICY NUMBER:	DPP: IPC-020	APPLIES TO: pt care unit
	TITLE:	SINGLE ROOM USE FOR ISOLATION PRECAUTIONS	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 3

1. PURPOSE

To provide guidelines on the appropriate use of single rooms for isolating patient suspected or confirmed with communicable diseases.

2. DEFINITION

3. RESPONSIBILITIES

All hospital staff

4. COMMENTS

4.1 Appropriate patient placement is an important component of isolation precautions, which are designed to do the following:

a. Provide a physical barrier around the patient infected or colonized with epidemiologically significant microorganisms.

b. Remind personnel and visitors to observe infection control measures.

4.2 Consult with the Infection Preventionist (IP) to verify proper patient placement as necessary.

5. PROCEDURE

5.1 . Single Rooms

5.1.1 Use a single room with hand hygiene and toilet facilities for isolation purposes.

5.1.2 Use a single room with negative pressure (airborne infectious isolation room (AIIR)) for airborne isolation precautions. (NOT APPLICABLE AS IT IS NOT AVAILABLE IN HGH. PATIENTS WHO NEED NEGATIVE PRESSURE ISOLATION ROOM HAVE TO BE TRANSFERRED TO DIFFERENT HOSPITAL WITH THIS FACILITY.)

5.1.3 Post the appropriate isolation sign on the door to indicate the isolation precaution(s) required.

5.1.4 Place isolation carts with the necessary supplies outside the single room.

5.1.5 Consult with IP to cohort patients with identical organisms/disease when there is a shortage of single rooms.

5.2 Indication for Single Room

5.2.1 Refer to A Quick Reference Guide to initiate isolation based on the type of suspected/diagnosed infection or infectious disease.

5.2.2 Place the patient in a single room for the duration of infectivity of the



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DEPARTMENTAL POLICY PROCEDURE

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patient.

- 5.2.3 When a patient has poor hygienic habits and cannot comply with infection control practices, consult with IP.

5.3 Admission Process

- 5.3.1 The attending physician documents confirmed or suspected infectious status of patients that require isolation.
- 5.3.2 Admitting wards (OPD, ER) notify Infection Prevention & Control.
- 5.3.3 IP and the Admissions Department will confer to determine the need for a single room.
- 5.3.4 The receiving ward and admission office shall notify IP when a patient is placed in single-room isolation.
- 5.3.5 If a single room in an OFF-SERVICE ward is utilized, the Admissions Department shall transfer the patient to the appropriate service ward as soon as the required room becomes available.
- 5.3.6 The IP shall monitor the patient's progress and advise on rescreening and discontinuation of isolation.
- 5.3.7 The ward staff shall notify the Admissions Office when isolation is discontinued.
- 5.3.8 Refer to Flowchart Infection Control Protocol for Use of Single Room for Isolation.

6. REFERENCES

- General Directorate of Infection Prevention and Control (MOH)
- GCC 3rd Edition (2018)



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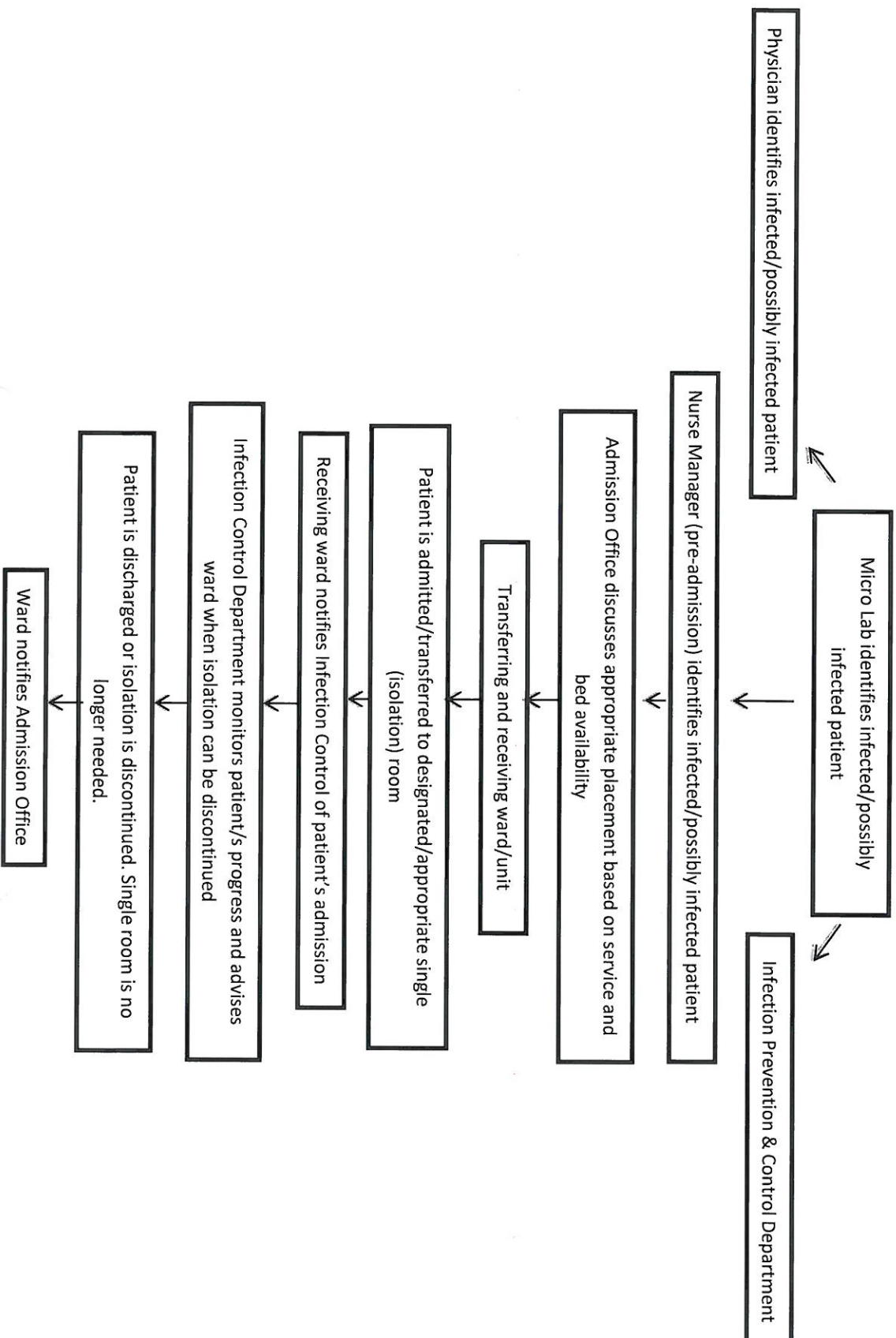
6. APPROVALS

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Kubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



FLOWCHART

Infection Control Protocol for the use of Single Rooms for Isolation





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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE			
APP VERSION:2	POLICY NUMBER:	APP: IPC-021	APPLIES TO: HOSPITAL WIDE
	TITLE:	TRANSPORTING PATIENTS ON ISOLATION PRECAUTIONS	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 3

1.0. PURPOSE:

- 1.1.To provide clear guidelines to safely transporting isolated patients within the facility while preventing or minimizing infection transmission.

2.0. DEFINITION:

- 2.1. N/A

3.0. POLICY:

- 3.1. Transport of isolated patients should be limited to essential purposes only, such as diagnostic and therapeutic procedures that cannot be performed in the patient's room.
- 3.2. When patient transport is necessary, appropriate barriers (e.g., masks, leak-proof dressing) should be worn to reduce potential contamination of the environment and the spread of infection.
- 3.3.Refer to *Isolation (Expanded) Precautions policy* in this manual for specific isolation precautions.
- 3.4. All staff must observe Standard Precautions at all times.

4.0. RESPONSIBILITY:

- 4.0. It is the responsibility of the Infection Prevention and Control Department to implement the program within the health care settings.
- 4.1. It is the responsibility of the staff to follow proper precautions while transporting patient.

5.0. PROCEDURE:

5.1. Ward

- 5.1.1. Notify the receiving department to which the patient is being transported of the isolation precautions in effect.



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- 5.1.2. Instruct the patient of the ways that he/she can assist in maintaining appropriate precautions to prevent transmission of the infection.
- 5.1.3. Dress wounds with impervious dressings as required.
- 5.1.4. Dress the patient in a clean gown.
- 5.1.5. Explain to the patient the need for the protective apparel that he/she is required to wear.

5.1.5.1. Put a mask on any patient who is in airborne isolation.

- 5.1.6. Cover the wheelchair/stretchers with a sheet before moving the patient.
- 5.1.7. Cover the patient with a clean sheet.
- 5.1.8. Transport the patient to the area as required.
- 5.1.9. Return the patient to the isolation room as soon as circumstances allow.
- 5.1.10. Clean and disinfect the wheelchair or stretchers with the approved disinfectant.

5.2. Receiving Department

- 5.2.1. HCWs are to use appropriate personal protective equipment (PPE) when managing the patient.
- 5.2.2. Observe the specified isolation techniques.
- 5.2.3. Adhere to the Hand Hygiene policy.
- 5.2.4. Arrange for the patient's return to his/her ward as soon as possible.
- 5.2.5. Change linens and clean equipment and environmental surfaces as indicated before receiving the next patient.

5.3. Transferring the patient to another facility

- 5.3.1. Inform the receiving facility and the emergency vehicle personnel in advance about the type of isolation and standard precautions (PPE) required.
- 5.3.2. Provide complete information on the infectious status of the patient to the receiving facility.

6.0. MATERIAL/EQUIPMENT:

6.1. N/A



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7.0. REFERENCE:

7.1.GCC Manual for Infection Control, 3rd Edition (2018)

8.0.APPROVALS :

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
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	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		20-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE

IPP VERSION:2	POLICY NUMBER:	IPP: IPC-022	APPLIES TO: PT CARE AREAS
	TITLE:	INITIATING AND DISCONTINUING ISOLATION	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1. PURPOSE:

- 1.1. To provide guidelines on the process of initiating and discontinuing isolation precautions for patients with a confirmed or suspected infectious diseases that carries the risk of nosocomial transmission.

2. DEFINITIONS

N/A

3. POLICY:

- 3.1. Standard precautions must always be observed while delivering direct patient care.
3.2. Appropriate isolation signs must be placed on the doors as needed.
3.3. Patients requiring isolation precaution can be identified by laboratory results, physician diagnosis, or any existing flagging system.

4. RESPONSIBILITY:

- 4.1. It responsibilities of the Infection Prevention and Control Department and HCWs to implement the program within the health care settings.

5. PROCEDURE:

5.1. Physician

- 5.1.1. Identify patients with either a suspected or confirmed infectious diseases.
5.1.2. Where possible, this information should be available on the patient's chart upon admission or as soon as the infection becomes apparent.

5.2. Nurses

- 5.2.1. Confer with physician(s) regarding suspected/diagnosed infections.
5.2.2. Notify Infection control practitioner (ICP) for assistance regarding the type of isolation to be used.
5.2.3. Request the appropriate single room from the Admissions Office Bed Coordinator.
5.2.4. Place the patient in an appropriate room (some patients with the same type of infection can be cohorted ; ICP will advise).
5.2.5. Place the appropriate isolation sign on the outside of the door of the patient's room.
5.2.6. Ensure that the appropriate isolation precautions are maintained for the duration of the infectivity of the patient.
5.2.7. Fill out a Report of Communicable Diseases Form for all diagnosed cases of reportable diseases for the MOH. (Refer to policy IPC-014 reporting communicable diseases to the ministry of health).
5.2.8. Discontinue isolation in consultation with ICP.
5.2.9. Notify the Admissions Office when isolation is discontinued.
5.2.10. Request housekeeping staff to carry out a terminal cleaning of the isolation room (Refer to policy IPC-045 housekeeping).



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Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE			
APP VERSION:2	POLICY NUMBER:	IPP: IPC-023	APPLIES TO: HOSPITAL WIDE
	TITLE:	Surveillance Of Healthcare Associated Infection	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1.0. PURPOSE:

- 1.1. To provides a quick reference guide for the selection of the appropriate isolation precaution(s). Each disease and condition in considered individually; only those precautions that are indicated to interrupt transmission for the disease/condition in question are recommended.

2.0. DEFINITION:

- 2.1. **Isolation (transmission based) Precautions** - are designed for patients who are known or suspected to be infected with epidemiologically important pathogens that can be spread by the airborne, droplet, or contact routes.
- 2.2. **Standard Precautions** - are those designed for the care of all patients in the hospital regardless of their diagnosis or presumed infection status.

3.0. POLICY:

- 3.1. Isolation system must use as a guide to any infectious diseases or transmissible pathogens.
- 3.2. Implementation of Standard Precautions is the primary strategy for successful nosocomial prevention and control.

4.0. RESPONSIBILITY:

- 4.1. It is the responsibility of all the staffs to follow the isolation precautions to any suspected or confirmed case of infectious diseases or transmissible pathogens.
- 4.2. It is the responsibility of the health care workers to follow standard precautions in dealing with the patients.

5.0. PROCEDURE:

- 5.1. Refer to Appendix 1 – Isolation Systems: A Quick Reference Guide



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE

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KEY	
C	Contact isolation
CN	Culture negative (with specified amount)
D	Droplet precautions
DE	Decontamination of environment
DH	Duration of hospitalization
DI	Duration of illness
LC	Lesions crusted
A	Airborne precautions
S	Standard precautions
SAPP	Special Administrative Policy and Procedure
U	Time (in hours or days) after the initiation of effective antimicrobial Therapy
U ^R	Time (in days) after onset of rash
U ^S	Time (in days) after onset of swelling

6.0. MATERIAL/EQUIPMENT:

6.1. N/A

7.0. REFERENCE:

7.1. GCC Manual for Infection Control 3rd Edition Manual(2018)



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE

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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

DEPARTEMENTAL POLICY AND PROCEDURE			
DPP VERSION:2	POLICY NUMBER:	DPP: IPC-024	APPLIES TO: ICU
	TITLE:	VENTILATOR ASSOCIATED EVENTS	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1.0 PURPOSE:

- 1.1. To provide a guideline for surveillance method in order to measure the incidence of HAIs and organisms and establish their endemic rates through using standard definitions and methods to allow benchmarking both local, regional, and international.

2.0.DEFINITION:

- 2.1. **Ventilator - Associated Events (VAE) events** - are identified by using a combination of objective criteria: deterioration in respiratory status after a period of stability or improvement on the ventilator, evidence of infection or inflammation, and laboratory evidence of respiratory infection
- 2.2. **Ventilator** - is defined as a device to assist or control respiration continuously, inclusive of the weaning period, through a tracheostomy or by endotracheal intubation. The ventilator has to be in place for >2 days.
- 2.3. The **VAE** definition algorithm is for use in surveillance; it is not a clinical definition algorithm and is not intended for use in the clinical management of patients.
- 2.4. **Three tiers of VAE definitions - hierarchical**
 - 2.4.1. Ventilator-Associated Condition (VAC)
 - 2.4.2. Infection-related Ventilator-Associated Complications (IVAC)
 - 2.4.3. Possible Ventilator-Associated Pneumonia (PVAP)

3.0,RESPONSIBILITY:

- 3.1. It is the responsibility of all HCWs to follow standard precautions and aseptic technique for all direct patients' care and to enter the surveillance bundle form for all ventilated patients.
- 3.2. It is the responsibility of the IPC Practitioner to monitor and collect data for surveillance.

4.0. POLICY:

- 4.1. **Surveillance Settings:**
 - 4.1.1. VAE surveillance can be done in any inpatient location where denominator data can be collected.
 - 4.1.2. Currently it is implemented in adult ICUs and SCA, step-down units, wards
- 4.2. **Surveillance Methodology:**
 - 4.2.1. Active



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

DEPARTEMENTAL POLICY AND PROCEDURE			
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- 4.2.2. Patient Based
- 4.2.3. Prospective
- 4.2.4. Priority-directed targeted
- 4.2.5. Yield risk-adjusted incidence rates

4.3. Ventilator:

- 4.3.1. Any device used to support, assist or control respiration (inclusive of the weaning period) through the application of positive pressure to the airway when delivered via an artificial airway, specifically an oral/nasal endotracheal or tracheostomy tube.
- 4.3.2. Lung expansion devices such as intermittent positive-pressure breathing (IPPB); nasal positive end-expiratory pressure (nasal PEEP); and continuous nasal positive airway pressure (CPAP, hypo CPAP) are not considered ventilators unless delivered via tracheostomy or endotracheal intubation (e.g., ET-CPAP).
- 4.3.3. Patients on Airway Pressure Release Ventilation (APRV) or related modes of mechanical ventilation (e.g., BiLevel, Bi Vent, BiPhasic, PCV+, DuoPAP) are INCLUDED in VAE protocol, but the VAE period of stability or improvement on the ventilator and the period of worsening oxygenation should be determined by changes in FiO₂ only, since changes in PEEP may not be applicable to APRV.

4.4. Ventilator removal and reinsertion:

- 4.4.1. If ventilator was removed and reinserted before a full calendar day without a ventilator, then continue the day count.
- 4.4.2. Therefore, if the patient is without a ventilator for at least one full calendar day (NOT to be read as 24 hours), then start a new day count.

4.5. Date of Event (DOE)

- 4.5.1. The date of onset of worsening oxygenation
- 4.5.2. This is defined as the first calendar day of the required 2: 2-day period of worsening oxygenation following a 2: 2-day period of stability or improvement on the ventilator.

4.6. Infection Window Period:

- 4.6.1. It is usually a 5-day period and includes the 2 days before, the day of, and the 2 days after the VAE event date (i.e., the first day of worsening oxygenation, the day of VAE onset).
- 4.6.2. However, it could be shorter if VAE occurs early in the course of mechanical ventilation (cannot include the first 2 days on ventilator)



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

DEPARTEMENTAL POLICY AND PROCEDURE

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4.6.3. The earliest day on which VAE criteria can be fulfilled is day 4 of mechanical ventilation (where the day of intubation and initiation of mechanical ventilation is day 1)

4.6.4. The earliest date of event for VAE (the date of onset of worsening oxygenation) is day 3 of mechanical ventilation

4.7. Location of Attribution:

4.7.1. The inpatient location where the patient was assigned on the date of the VAE event, which is further defined as date of onset of worsening oxygenation.

4.7.2. OR/Post Anesthesia Care Unit/Recovery Room/dialysis unit /ERs cannot be considered a location of attribution for VAE.

4.8. Transfer Rule:

4.8.1. If a VAE develops on the day of transfer or the day following transfer from one inpatient location to another in the same facility or to a new facility (where the day of transfer is day 1), the event is attributed to the transferring location.

4.8.1.1. Example:

4.8.1.1.1. Patient on a ventilator in the SICU who has had improving oxygenation for 3 days is transferred to the MICU, still on the ventilator.

4.8.1.1.2. On the day of transfer, after the patient has arrived in the MICU, the patient experiences an acute decompensation, requiring an increase of 0.30 (30 points) in FiO₂ that persists during the following calendar day.

4.8.1.1.3. VAC criteria are met on calendar day 2 in the MICU.

4.8.1.1.4. Because the onset of worsening oxygenation occurred on the day of transfer to the MICU, the VAC event is attributed to the SICU.

4.9. Multiple Transfers:

4.9.1. If the patient has been transferred to more than one location on the date of VAE, or the day before, attribute the VAE to the first location in which the patient was housed the day before the VAE's date of event.

4.10. Repeat Infection Time Frame (RIT):

4.10.1. A new VAE cannot be identified or reported until a 14-day period has elapsed after the day of onset of worsening oxygenation (the event date, day 1). However, the period of stability can be diagnosed during the defined 14 days

4.11. Secondary BSIs:



Kingdom of Saudi Arabia
Ministry of Health
Jazan Health Directorate
AL-Harth General Hospital



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- 4.11.1. Secondary BSIs may be reported for PVAP events but NOT reported for VAC orIVAC events provided that the organism identified from blood specimen matches an organism identified from an appropriate respiratory specimen (respiratory secretions, pleural fluid and lung tissue).
- 4.11.2. Collection times: respiratory specimen have been collected during the 5-day infection window and the positive blood specimen collected during the 14-day event period starting by the date of event
- 4.11.3. In cases where PVAP is met with only the histopathology criterion and there is a positive blood specimen a secondary BSI is not reported
- 4.11.4. Do not limit reporting to just those organisms isolated in culture. For example, influenza A identified by PCR in respiratory specimen and culture of blood specimen, a secondary BSI is reported
- 4.12. **Measurements of oxygen requirement:**
 - 4.12.1. Fraction of Inspired Oxygen (FiO₂) is oxygen concentration (%) is typically maintained below 0.5 even with ventilation, to avoid oxygen toxicity. Natural air includes 20.9% oxygen, which is equivalent to FiO₂ of 0.21.
 - 4.12.2. Positive end-expiratory pressure (PEEP) is the pressure in the lungs above atmospheric pressure applied by a ventilator. A small amount of applied PEEP (0 to 5 cmH₂O) is used in most mechanically ventilated patients to mitigate end- expiratory alveolar collapse.
- 4.13. **Daily minimum PEEP:**
 - 4.13.1. The lowest value of PEEP during a calendar day that is set on the ventilator and maintained for at least 1 hour
 - 4.13.2. In the event that ventilator settings are monitored and recorded less frequently than once per hour or where there is no value that is documented to have been maintained for at least one hour, the daily minimum PEEP is simply the lowest value of PEEP set on the ventilator during the calendar day
- 4.14. **Daily minimum FiO₂:**
 - 4.14.1. The lowest value of FiO₂ during a calendar day that is set on the ventilator and maintained for at least 1 hour
 - 4.14.2. In the event that ventilator settings are monitored and recorded less frequently than once per hour or where there is no value that has been maintained for at least one hour, the daily minimum FiO₂ is simply the lowest value of FiO₂ set on the ventilator during the calendar day.
- 4.15. **Layers of VAE events**



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4.15.1. **Ventilator-Associated Condition (VAC):** After a period of stability or improvement on the ventilator sustained for 2 calendar days, the patient has one the following indicators of worsening oxygenation that sustained for 2: 2 calendar days;

4.15.1.1. Increase in daily minimum FiO₂ values of 0.20 points or

4.15.1.2. Increase in daily minimum PEEP values of 3 cm H₂O

4.15.2. **Infection-related Ventilator-Associated Complication (IVAC):** After meeting the criteria of VAC, the patient meets the following two criteria;

4.15.2.1. Temperature > 38 °C or < 36°C, OR white blood cell count 2: 12,000 cells/mm³ or 4,000 cells/mm³

4.15.2.2. A new antimicrobial **agent(s)** is started, and is continued for 4 calendar days

4.15.3. **Possible Ventilator-Associated Pneumonia (PVAP):** After meeting the criteria of VAC or IVAC, the patient meets one of the following criteria;

4.15.3.1. **Criterion 1:** Positive culture of respiratory specimens without requirement for purulent respiratory secretions.

4.15.3.2. **Criterion 2:** Purulent respiratory secretions plus organism identified from defined respiratory specimens.

4.15.3.3. **Criterion 3:** One of the following positive tests: Organism identified from pleural fluid, Lung histopathology, Legionella detection, or viral detection.

5.0. PROCEDURE:

5.1. Ventilator-Associated Condition (VAC)

5.1.1. After a period of stability or improvement on the ventilator sustained for 2 calendar days, the patient has one the following indicators of worsening oxygenation;

5.1.1.1. Increase in daily minimum FiO₂ values of 0.20 points or

5.1.1.2. Increase in daily minimum PEEP values of 3 cm H₂O

5.2. Infection-related Ventilator-Associated Complication (IVAC)

5.2.1. After meeting the criteria of VAC, the patient meets the following two criteria;

5.2.1.1. Temperature > 38 °C or < 36°C, OR white blood cell count 12,000 cells/mm³ or 54,000 cells/mm³



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5.2.1.2. A new antimicrobial agent(s) is started, and is continued for 4 calendar days

5.2.2. **New antimicrobial agent:**

5.2.2.1. Any agent initiated on or after the third calendar day of mechanical ventilation and in the VAE Window Period

5.2.2.2. The agent is considered new for the purposes of this definition if it was not given to the patient during the 2-days before the window

5.2.2.3. Qualifying Antimicrobial Day (QAD): day on which the patient was administered an antimicrobial agent that was determined to be "new" within the VAE Window Period

5.2.2.4. Four consecutive QADs are needed to meet the IVAC antimicrobial criterion

5.2.2.5. The requirement for 4 consecutive QADs can be met with 4 days of therapy with the same antimicrobial (with a gap of no more than 1 calendar day between administrations of that antimicrobial) or it can be met with 4 days of therapy with multiple antimicrobial agents, as long as each antimicrobial was started within the VAE Window Period.

5.2.3. **Routes of administration of new antimicrobial agent**

5.2.3.1. **Route of Administration**

Route of Administration	Definition
Intravenous	An intravascular route that begins with a vein.
Intramuscular	A route that begins within a muscle
Digestive Tract	A route that begins anywhere in the digestive tract extending from the mouth through rectum.
Respiratory Tract	A route that begins within the respiratory tract, including the oropharynx and nasopharynx.

5.2.3.2. **Qualifying Antimicrobial Day (QAD):**

Ventilator days	2	3	4	5	6	7	8
Oxygenation		Stable/improve	Stable/improve	Worsen	Worsen		
Antimicrobial event	Ceftriaxone	Ceftriaxone	Ceftriaxone	Meropenem	Meropenem	Meropenem	Meropenem
QAD				1	2	3	4



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5.2.3.2.1. Meropenem is a new start while ceftriaxone is not as it was given to the patient the day before the 5-day period (infection window period).

5.2.3.2.2. The number of QAD is 4

Ventilator days	2	3	4	5	6	7	8
Oxygenation		Stable/improve	Stable/improve	Worsen	Worsen		
Antimicrobial agent	Ceftriaxone	Ceftriaxone	Ceftriaxone	Meropenem	Imipenem	Piperacillin/Tazobactam	Piperacillin/Tazobactam
QAD				1	2	3	4

5.2.3.2.3. Meropenem, Imipenem and Piperacillin/ Tazobactam are new start while ceftriaxone is not as it was given to the patient the day before the 5-day period.

5.2.3.2.4. The number of QAD is 4

Ventilator days	2	3	4	5	6	7	8
Oxygenation		Stable/improve	Stable/improve	Worsen	Worsen		
Antimicrobial event			Levofloxacin		Levofloxacin		Levofloxacin
QAD				1	2	3	4

5.2.3.2.5. Because there is a gap of no more than 1 calendar day between days of levofloxacin administration, the requirement for 4 consecutive QADs is met

5.2.3.2.6. The number of QAD is 5



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Ventilator days	2	3	4	5	6	7	8
Oxygenation		Stable/improve	Stable/improve	Worsen	Worsen		
Antimicrobial			Vancomycin			Vancomycin	
QAD				1	2	3	4

5.2.3.2.7. Because there is a gap of more than 1 calendar day between days of vancomycin administration, the requirement for 4 consecutive QADs is not met

5.2.3.2.8. The number of QAD is 0

5.3. Possible Ventilator-Associated Pneumonia (PVAP):

After meeting the criteria of VAC or IV AC, the patient meets one of the following criteria;

5.3.1. **Criterion 1:** Positive culture of one of the following specimens, meeting quantitative or semi-quantitative thresholds, without requirement for purulent respiratory secretions:

5.3.1.1. Endotracheal aspirate, 10^5 CFU/ml or corresponding semi-quantitative result

5.3.1.2. Bronchoalveolar lavage, 10^4 CFU/ml or corresponding semi-quantitative result

5.3.1.3. Lung tissue, 10^4 CFU/g or corresponding semi-quantitative result

5.3.1.4. Protected specimen brush, 10^3 CFU/ml or corresponding semi-quantitative result

5.3.2. **Criterion 2:** Purulent respiratory secretions PLUS organism identified from one of the following specimens (to include qualitative culture, or quantitative/semi-quantitative culture without sufficient growth to meet criterion #1)

5.3.2.1. Sputum

5.3.2.2. Endotracheal aspirate

5.3.2.3. Bronchoalveolar lavage

5.3.2.4. Lung tissue

5.3.2.5. Protected specimen brush

5.3.3. **Criterion 3:** One of the following positive tests:



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- 5.3.3.1. Organism identified from pleural fluid (where specimen was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube)
- 5.3.3.2. Lung histopathology, defined as: 1) abscess formation or foci of consolidation with intense neutrophil accumulation in bronchioles and alveoli; 2) evidence of lung parenchyma invasion by fungi (hyphae, pseudohyphae or yeast forms); 3) evidence of infection with the viral pathogens listed below based on results of immunohistochemical assays, cytology, or microscopy performed on lung tissue
- 5.3.3.3. Diagnostic test for Legionella species
- 5.3.3.4. Diagnostic test on respiratory secretions for influenza virus, respiratory syncytial virus, adenovirus, parainfluenza virus, rhinovirus, human metapneumovirus, coronavirus

Criterion 1-PVAP: Threshold values for cultured specimens used in the diagnosis of pneumonia

Specimen collection/technique	Values*
Lum? tissue	> 10 ⁴ CFU/g tissue
Bronchoscopically (B) obtained specimens	
• Broncho alveolar lavage (B-BAL)	10 ⁴ CFU/ml
• Protected BAL (B-PBAL)	10 ⁴ CFU/ml
• Protected specimen brushing (B-PSB)	10 ³ CFU/ml
Non bronchoscopically (NB) obtained (blind) specimens	
• NB-BAL	10 ⁴ CFU/ml
• NB-PSB	10 ³ CFU/ml
8. Endotracheal aspirate (ETA)	10 ⁵ CFU/ml

5.4. Collection of denominator data for VAE

5.4.1. Manual daily:

- 5.4.1.1. patient days and ventilator days should be collected at the same time, every day, for each location performing surveillance to ensure that different collection methods don't result in device days being > patient days.

5.4.2. Electronic sources:



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5.4.2.1. When patient days and ventilator days are available from electronic databases, these sources may be used as long as the counts are not substantially different (+/- 5%) from those collected manually.

5.5. Analysis of VAE

Measure	Calculation	Application
VAE Rates	The number of VAEs for a location X 1000	Location specific measure
	The number of ventilator days for that location	
VAE Rates	The number of VAEs for a location X 100	Location specific measure
	The number of ventilator episodes for that location	
VAESIR	The number of observed VAEs	Both location specific and summarized measure
	The number of predicted VAEs	
Ventilator DUR	The number of ventilator days for a location	Location specific measure
	The number of patient days for that location	
Ventilator SUR	The number of observed ventilator days	Both location specific and summarized measure
	The number of predicted ventilator days	

SIR= Standardized Infection Ratio; DUR= Device Utilization Ratio; SUR= Standardized Utilization Ratio

6.0. MATERIAL/EQUIPMENT:

6.1. Surveillance Bundle form

7.0. REFERENCE:

7.1. MOH Surveillance Manual 2021



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8.0.APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	RT. Hasna	RT SUPERVISOR		8-7-2021
	Mr. fahd najmi	Nursing director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Mrs. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



VENTILATOR ASSOCIATED EVENT (VAE) MONITORING FORM

[illegible]

MV = mechanical ventilation. PEEP min = Daily minimum PEEP. PEEP max = Daily maximum PEEP. ABX = antimicrobial agents. Polys / eps = Polymorphonuclear leukocytes and squamous epithelial cells from respiratory specimen. Temp min = Daily minimum temperature. Temp max = Daily maximum temperature. WBC min = Daily minimum white blood cell count. WBC max = Daily maximum white blood cell count. ABX = antimicrobial agents. Polys / eps = Polymorphonuclear leukocytes and squamous epithelial cells from respiratory specimen. VAE Type: VAC = increase in daily min FIO₂ of $\geq 20\%$ over the first day in the baseline period, sustained for ≥ 2 calendar days OR increase in daily min PEEP values of ≥ 2 cmH₂O over the first day in the baseline period sustained for ≥ 2 calendar days; IVAC = Temperature $< 35^{\circ}\text{C}$ or $> 38^{\circ}\text{C}$, white blood cell counts $\leq 4,000$ cells/mm³ or $\geq 12,000$ cells/mm³; a new antimicrobial agent started and continued for ≥ 4 days; PVARP = 1 positive culture (LTA: BAL, Lung Tissue, Protective specimen brush); 2 purulent resp. secretions (lungs, bronchi, trachea & neurotopically and / or squamous epithelial cells PLUS organisms from sputum, endotracheal asp; bronchial lavage; lung tissue; protected specimen brush; 3 positive test in pleural fluid; lung histopath; dx test for influenza virus, RSV, Adenovirus, parainfluenza virus, rhinovirus, coronavirus)

ORGANISM AND SENSITIVITY

Patient's Name:		MRN:		Unit/Ward:	
Age:		Gender: M/F		Date/Time of Specimen Collection:	
				Date /Time of Record:	
Type of Specimen: <input type="checkbox"/> Sputum <input type="checkbox"/> Throat swab <input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> blood <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Body tissue <input type="checkbox"/> Wound swab <input type="checkbox"/> Tracheal aspirate <input type="checkbox"/> Body fluids <input type="checkbox"/> Others <input type="checkbox"/> Stool					
Name of Organism/s:					
ANTIMICROBIAL SENSITIVITY:					
For Gram Positive Organism		For Gram Negative organism		For Fungus Organism	
For Mycobacterial Organism					
1. Ciprofloxacin	1. Amikacin	16. Colistin	1. Amifulafungin	1. Ciprofloxacin	
2. Levofloxacin	2. Ampicillin	17. Polymycin B	2. Caspofungin	2. Isoniazid	
3. Moxifloxacin	3. Ampicillin sulbactam	18. Ertapenem	3. Fluconazole	3. Rifampicin	
4. Clindamycin	4. Aztreonam	19. Gentamicin	4. Flucytosine	4. Ethambutol	
5. Daptomycin	5. Amoxiclav	20. Imipenem	5. Iitraconazole	5. Pyrazinamide	
6. Doxycycline	6. Cefazolin	21. Meropenem	6. Micofungin	6. Clarithromycin	
7. Minocycline	7. Cefepime	22. Doripenem	7. Variconazole	7. Capreomycin	
8. Erythromycin	8. Cefotaxime	23. Piperacillin/Tazobactam		8. Cycloserine	
9. Gentamicin	9. Cefuroxime	24. Tetracycline		9. Kanamycin	
10. Linezolid	10. Ceftriaxone	25. Doxycycline		10. Amikacin	
11. Oxacillin	11. Ceftazidime	26. Minocycline		11. Streptomycin	
12. Cefoxitin	12. Cefoxitin	27. Tigecycline			
13. Methicillin	13. Cefotetam	28. Levofloxacin			
14. Rifampicin	14. Ciprofloxacin	29. Moxifloxacin			
15. Tetracycline	15. Trimethoprim Sulfamethoxazole	30. Tobramycin			
16. Trimethoprim Sulfamethoxazole					
17. Vancomycin					

• Write for every antibiotic according to their sensitivity: S- Susceptible I- Intermediate R- Resistant NT- not tested

Ventilator-Associated Event (VAE)

****required for completion**

*Medical Record No (MRN):	National ID/IQAMA #:	
Patient Name (4 names)	Client ID:	
*Gender: F M	Age:	Nationality (Specify):
*Event Type: VAE	*Date of Event:	
Post-procedure VAE: Yes No	Date of Procedure:	
*Date Admitted to Facility:	*Location:	
*Location of Mechanical Ventilation Initiation: _____	*Date Initiated: __/__/____	*APRV: Yes No (Airway Pressure Release Ventilation)

Event Details

*Specific Event: ☐ VAC ☐ IVAC ☐ Possible VAP

*Specify Criteria Used:

STEP 1: Ventilator Associated Condition (VAC)
After a period of stability or improvement on the ventilator, the patient has at least one of the following indicators of worsening oxygenation:

☐ Increase in daily minimum* FiO_2 of ≥ 0.20 (20 points) over the daily minimum FiO_2 of the first day in the baseline period, sustained for ≥ 2 calendar days. **OR** ☐ Increase in daily minimum* PEEP values of ≥ 3 cmH_2O over the daily minimum PEEP of the first day in the baseline period† sustained for ≥ 2 calendar days.

*Daily minimum defined by lowest value of FiO_2 or PEEP during a calendar day that is maintained for > 1 hour.
*Daily minimum PEEP values of $0.5 \text{ cmH}_2\text{O}$ are considered equivalent for the purposes of VAE surveillance.

STEP 2: Infection- related Ventilator Associated Complication (IVAC)
On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation (infection window period), the patient meets both of the following:

☐ Temperature $> 38^\circ\text{C}$ or $< 36^\circ$ **OR** ☐ White blood cell count $\geq 12,000$ or $\leq 4,000$ cells/ mm^3

AND

☐ A new antimicrobial agent(s) is started, and is continued for ≥ 4 qualifying antimicrobial days (QAD).

STEP 3: Possible Ventilator Associated Pneumonia (PVAP)
On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, ONE of the following criteria is met (taking into account organism exclusions specified in the protocol):

☐ **Criteria 1:**
Positive culture of one of the following specimens, meeting quantitative or semi quantitative thresholds* as outlined in protocol, without requirement for purulent respiratory secretions:

- Endotracheal aspirate, $\geq 10^5$ CFU/ml or corresponding semi-quantitative result
- Bronchoalveolar lavage, $\geq 10^4$ CFU/ml or corresponding semi-quantitative result
- Lung tissue, $\geq 10^4$ CFU/g or corresponding semi-quantitative result
- Protected specimen brush, $\geq 10^3$ CFU/ml or corresponding semi-quantitative result

☐ **Criteria 2**
Purulent respiratory secretions (defined as secretions from the lungs, bronchi, or trachea that contain >25 neutrophils and <10 squamous epithelial cells per low power field [lpf, $\times 100$]) * PLUS organism identified from one of the following specimens (to include qualitative culture, or quantitative/semi-quantitative culture without sufficient growth to meet criterion #1):

- Sputum
- Endotracheal aspirate
- Bronchoalveolar lavage
- Lung tissue
- Protected specimen brush

☐ **Criteria 3**
One of the following positive tests:

- *Organism identified from pleural fluid (where specimen was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube)
- Lung histopathology, defined as:
 - abscess formation or foci of consolidation with intense neutrophil accumulation in bronchioles and alveoli;
 - evidence of lung parenchyma invasion by fungi (hyphae, pseudohyphae or yeast forms);
 - evidence of infection with the viral pathogens listed below based on results of immunohistochemical assays, cytology, or microscopy performed on lung tissue
- Diagnostic test for Legionella species
- Diagnostic test on respiratory secretions for influenza virus, respiratory syncytial virus, adenovirus, parainfluenza virus, rhinovirus, human metapneumovirus, coronavirus

* If the laboratory reports semi-quantitative results, those results must correspond to the quantitative thresholds.
* If organism identified, specify the name: _____

*Secondary Bloodstream Infection: Yes No

**Died: Yes No VAE Contributed to Death: Yes No

Discharge Date: _____ *Pathogens Identified: Yes No *If Yes, specify name of Organism: _____

ORGANISM AND SENSITIVITY

Patient's Name:		MRN:		Unit/Ward:	
Age:		Gender: M/F		Date/Time of Specimen Collection:	
				Date /Time of Record:	
Type of Specimen: <input type="checkbox"/> Sputum <input type="checkbox"/> Throat swab <input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> blood <input type="checkbox"/> Urine <input type="checkbox"/> BAL <input type="checkbox"/> Body tissue <input type="checkbox"/> Wound swab <input type="checkbox"/> Tracheal aspirate <input type="checkbox"/> Body fluids <input type="checkbox"/> Others <input type="checkbox"/> Stool					
Name of Organism/s:					
ANTIMICROBIAL SENSITIVITY:					
For Gram Positive Organism		For Gram Negative organism		For Fungus Organism	
For Mycobacterial Organism					
1. Ciprofloxacin		1. Amikacin		1. Amifulafungin	1. Ciprofloxacin
2. Levofloxacin		2. Ampicillin		2. Caspofungin	2. Isoniazid
3. Moxifloxacin		3. Ampicillin sulbactam		3. Fluconazole	3. Rifampicin
4. Clindamycin		4. Aztreonam		4. Flucytosine	4. Ethambutol
5. Daptomycin		5. Amoxiclav		5. Iitraconazole	5. Pyrazinamide
6. Doxycycline		6. Cefazolin		6. Micafungin	6. Clarithromycin
7. Minocycline		7. Cefepime		7. Variconazole	7. Capreomycin
8. Erythromycin		8. Cefotaxime			8. Cycloserine
9. Gentamicin		9. Cefuroxime			9. Kanamycin
10. Linezolid		10. Ceftriaxone			10. Amikacin
11. Oxacillin		11. Ceftazidime			11. Streptomycin
12. Cefoxitin		12. Cefoxitin			
13. Methicillin		13. Cefotetam			
14. Rifampicin		14. Ciprofloxacin			
15. Tetracycline		15. Trimethoprim Sulfamethoxazole			
16. Trimethoprim Sulfamethoxazole					
17. Vancomycin					

• Write for every antibiotic according to their sensitivity: S- Susceptible I- Intermediate R- Resistant NT- not tested

Ventilator Associated Pneumonia Form

Laboratory Findings

* If immunocompromised, Does the patient have any of the following Lab results?

- ☐ Identification of matching Candida spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing
☐ Evidence of fungi from minimally contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: (1) Direct microscopic exam (2) Positive culture of fungi (3) Non-culture diagnostic laboratory test

VAP Criteria that patient has:

PNEU 1 ☐

PNEU 2 ☐

PNEU 3 ☐

VAP Diagnosed after a Procedure: Yes ☐ No ☐

Procedure Name (encircle the procedure)

Craniotomy	Limb amputation	Gallbladder surgery	Abdominal hysterectomy	Open reduction of fracture
Cesarean section	Appendix surgery	Colon surgery	Knee prosthesis	Abdominal aortic aneurysm repair
Spinal fusion	Shunt for dialysis	Heart transplant	Kidney transplant	Bile duct, liver or pancreatic surgery
Gastric surgery	Breast surgery	Liver transplant	Neck surgery	Laminectomy
Herniorrhaphy	Cardiac surgery	Carotid endarterectomy	Hip prosthesis	
Coronary artery bypass graft with both chest and donor site incisions			Coronary artery bypass graft with chest incision only	

Procedure Date: (DD/MM/YYYY):

Development of Secondary BSI: Yes ☐ No ☐

Hospitalization Death: Yes ☐ No ☐

Death Date:

VAP Contributed to Death: Yes ☐ No ☐

Pathogens identified: Yes ☐ No ☐

If YES, specify in the next page

Ventilator Associated Pneumonia Form

Patient Information

*Medical Record No (MRN):	*National ID/IQAMA:	*Client HESN ID:
Patient Name (4 names)	*Gender: F <input type="checkbox"/> M <input type="checkbox"/>	Age:
Nationality (Specify):	Country:	Region/Health Affairs:
Telephone No:	Mobile No:	Additional ID:
Address type: Primary home <input type="checkbox"/> No fixed address <input type="checkbox"/> temporary address <input type="checkbox"/> postal address <input type="checkbox"/> vacation home <input type="checkbox"/>		
*Date Admitted to Facility:	*Location(Area/Unit):	

VAP (according to current CDC/NHSN Criteria's and Definition)

Event Date (DD/MM/YYYY): _____

1. Patient had a ventilator at the time of or removed within 2 calendar days before VAP diagnosis Yes ☐ No ☐

Age: ☐ Age ≤1 year ☐ Age 1 to ≤12 years ☐ Age > 12 to <70 years ☐ Age ≥ 70 years

Is the patient immunocompromised? Yes ☐ No ☐

Does the patient has underlying pulmonary or? cardiac disease? Yes ☐ No ☐

Are there 2 or more positive chest imaging test results obtained? Yes ☐ No ☐

Is there any of the following chest imaging? test results? Yes ☐ No ☐

2. There must be at least one of the following chest imaging test Results (or 2 if there is underlying disease) to continue:

- ☐ New or progressive and persistent infiltrate:
- ☐ Consolidation
- ☐ Cavitation
- ☐ Pneumatoceles (in ≤1 yr.)

Date of Onset of First Signs and Symptoms (DD/MM/YYYY): _____

VAP signs and symptoms:

- Temperature ☐ Fever (>38.0°C) ☐ Hypothermia (<36.0°C) ☐ Temperature instability
- WBC ☐ Leukopenia (≤4000 WBC/mm³) ☐ Leukocytosis (For adults, >12,000 WBC/mm³, children less than 12 yr. >15,000 WBC/mm³)

Laboratory Findings

- *Does the patient has any of the following Common Bacterial or Filamentous Fungal Pathogens Lab results
- ☐ Organism identified from blood
 - ☐ Organism identified from pleural fluid
 - ☐ Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing)
 - ☐ ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain) Positive quantitative culture of lung tissue
 - ☐ Positive quantitative culture of lung tissue
 - ☐ Histopathologic exam shows at least one of the following evidences of pneumonia: (1) Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli, (2) Evidence of lung parenchyma invasion by fungal hyphae or Pseudohyphae

VAP signs and symptoms:

- ☐ Altered mental status (in ≥70 y.o.) with no other recognized Cause
- ☐ New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements
- ☐ Cough (For adults, new onset or worsening)
- ☐ Apnea
- ☐ Dyspnea
- ☐ Tachypnea
- ☐ Rales or bronchial breath sounds
- ☐ Wheezing, rales, or rhonchi
- ☐ Heart Rate: Bradycardia (<100 beats/min) Tachycardia (>170 beats/min)
- ☐ Nasal flaring with retraction of chest wall or nasal flaring with grunting
- ☐ Worsening gas exchange (e.g., O₂ desaturations (e.g., PaO₂/FIO₂ <240), increased oxygen requirements, or increased ventilator demand)
- ☐ Hemoptysis
- ☐ Pleuritic chest pain
- ☐ Other Clinical Features (Please specify):

***Does the patient has any of the following Viral, Legionella, and other Bacterial Pathogens Lab results?**

- ☐ Virus, Bordetella, Legionella, Chlamydia or Mycoplasma identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., Not Active Surveillance Culture/Testing (ASC/AST).
- ☐ Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia)
- ☐ Fourfold rise in Legionella pneumophila serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect IFA.
- ☐ Detection of L. pneumophila serogroup 1 antigens in urine by RIA or EIA



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	TITLE:	PATIENTS AND SITTERS IN ISOLATION	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 4

1.0. PURPOSE:

- 1.1. To give guidelines on how to manage and achieve compliance from approved sitters of patients in isolation as per hospital policy and procedures.

2.0. DEFINITION:

- 2.1. N/A

3.0. POLICY:

- 3.1. Apply hospital administrative policies where applicable.
- 3.2. In general, sitters are not allowed for patients who are being treated in isolation (under airborne, contact, or droplet precautions). However, exceptions to this policy can be made after consultation and upon approval of the Director of the Infection Prevention and Control Program or a designee.
- 3.3. Every patient and approved sitter in isolation will follow standard and isolation precautions.
- 3.4. Compliance with all infection control practices is mandatory (e.g., those regarding hand hygiene, standard precautions, medical and nursing instructions, PPE).
- 3.5. Non-compliance with isolation regulations or infection control recommendations can contribute to the spread of infection to other patients, healthcare workers, visitors, and the environment.
- 3.6. It is the responsibility of the hospital staff to educate the isolated patient and approved sitter about all infection control rules and recommendations.

4.0. RESPONSIBILITY:

- 4.1. It is the responsibility of the doctor to make note if there are allowing sitter to be with the patient and explain to them the condition of the patient



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4.2. It is the responsibility of the infection control and staff nurse to educate patient's relative regarding the isolation precaution.

4.3. It is the responsibility of the assigned nurse to remind the staffs who will enter the room to wear proper PPE.

5.0. PROCEDURE:

5.1. Healthcare workers

5.1.1. The Most Responsible Physician or his/her designee is responsible for ensuring that the necessary education is given to the patient and sitter.

5.1.2. Each patient and sitter will be provided with specific information and will be given positive educational reinforcement in their language.

5.1.2.1. Evidence that this education has taken place will be documented in the patient's medical record by the physician.

5.1.2.2. The approved sitter will be informed at this time that sitter authorization will be withdrawn if isolation regulations are not followed.

5.1.2.3. The patient, sitter, and physician will sign the education consent form, and this form will be kept in the medical record as evidence that they agree to the isolation conditions.

5.1.2.4. Physicians, infection control practitioner, nurses, and health educators will share the responsibility of monitoring the compliance of the patient in isolation and his/her approved sitter.

5.1.2.5. The Infection Prevention and Control department (IP&C) should be informed immediately of any breaches of compliance.

5.1.2.5.1. The IP&C will recommend that further patient education should be given.

5.1.2.6. Any repeated breach of compliance should be referred to the IP&C, and the sitter's authorization can be withdrawn.

5.1.2.7. The Security Department will take whatever actions necessary to ensure that the patient in isolation and his/her approved sitter comply with infection control isolation precautions (if necessary).



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5.2. Patients and sitters

- 5.2.1. It is the responsibility of every patient and his/her approved sitter to comply with all infection control rules and regulations (listed on the sign on the door or conveyed through medical/nursing instructions).
- 5.2.2. It is the responsibility of the hospital staff to monitor the compliance of the patient in isolation and his/her allowed sitter with infection control isolation recommendations.
- 5.2.3. Patients and their sitters who receive education from the staff regarding infection control isolation recommendations and still do not comply with these recommendations will be subject to measures to enforce the standards and ensure their compliance.

6.0.MATERIAL/EQUIPMENT:

6.1. N/A

7.0.REFERENCE:

- 7.1.GCC Manual for Infection Control 3rd Edition Manual(2018)



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8.0. APPROVALS :

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Kubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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APP VERSION:2	POLICY NUMBER:	IPP: IPC-026	APPLIES TO: HOSPITAL WIDE
	TITLE:	GUIDELINES MANAGEMENT OF (MERS-CoV)	
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1.0. PURPOSE:

- 1.1. To provide a guideline on management for hospitalized patients with Middle East Respiratory Syndrome Corona Virus (MERS-CoV).

2.0. DEFINITION:

- 2.1. **MERS-CoV** is a novel corona virus first identified in September 2012 by an Egyptian virologist, who is isolated the previously unknown corona virus from the lungs of a 60 year old patient with pneumonia and renal failure.
- 2.2. Corona viruses are named for the **crown-like spikes** on their surface. They are common viruses that most people get in their lifetime; these viruses usually cause mild to moderate upper respiratory tract illnesses.
- 2.3. MERS-Cov is different from any other corona virus that caused SARS (Severe Acute Respiratory Syndrome).
- 2.4. Mode of Transmission:
- 2.4.1. The original source of MERS-CoV, routes of transmission to humans, and mode of human-to-human transmission have not been determined.
- 2.4.2. Health officials do not know how the newly discovered MERS-CoV spreads.
- 2.4.3. There is no reported evidence of sustained community transmission in any country.
- 2.4.4. All reported cases were directly or indirectly linked to one of four countries: Saudi Arabia, Qatar, Jordan, and the United Arab Emirates.
- 2.4.5. Cluster of cases occurred among close contacts or in healthcare settings, provide clear evidence of human-to-human transmission of MERS-CoV, possibly involving different modes, such as droplet, airborne and contact transmission.
- 2.5. **Case Definition**
- 2.5.1. **Suspected Case** (patient who should be tested for MERS-CoV)
- I. A person with fever and community-acquired pneumonia or



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acute respiratory distress syndrome based clinical or radiological evidence.

OR

- II. A hospitalized patient with healthcare associated pneumonia based on clinical and radiological evidence.

OR

- III. A person with 1) acute febrile ($\geq 38^{\circ}\text{C}$) illness, AND 2) body aches, headache, diarrhea, or nausea/vomiting, with or without respiratory symptoms, AND 3) unexplained leucopenia ($\text{WBC} < 3.5 \times 10^9/\text{L}$) and thrombocytopenia ($\text{platelets} < 150 \times 10^9/\text{L}$).

OR

- IV. A person (including health care workers) who had protected or unprotected exposure to a confirmed or probable case of MERS-CoV infection and who presents with upper or lower respiratory illness within 2 weeks after exposure.

2.5.2. Probable Case

2.5.2.1. Probable case is a patient in category I and II above with absent or inclusive laboratory results for MERS-CoV and other possible pathogens who is a close contact of a laboratory-confirmed MERS-CoV case or who works in a hospital where MERS-CoV cases are cared for.

2.5.3. Confirmed Case

2.5.3.1. A person with laboratory confirmation of infection with novel corona virus.

3.0. POLICY:

3.1. Healthcare facilities shall be having clear preparedness for any suspected/confirm case of MERS-COV including these following:

- 3.1.1. Review procedures for rapidly implementing appropriate isolation and infection practices for potential MERS-CoV patients.
- 3.1.2. Review policies and procedures for screening and work restrictions for exposed or ill HCW including ensuring that HCW have ready access/ including via telephone to medical



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consultations.

- 3.1.3. Review plans for implementation for laboratory submission of specimens for MERS-CoV testing.
- 3.1.4. Review plans for implementation of surge capacity procedures and crisis standards of care.
- 3.1.5. Develop plans for visitor restriction if MERS-CoV is circulating in the community.
- 3.1.6. Ensure that specific persons have been designated within the facility who are responsible for communication with public health official and dissemination of information to other HCW at the facility.
- 3.1.7. Confirm the public health department contact for reporting MERS-CoV cases and confirm reporting requirements.
- 3.1.8. Assure ability to implement triage activities based on public health guidance including at the facility and using remote (i.e., phone, internet based) methods. Ensure the negative pressure airborne infection isolation rooms are functioning correctly and are appropriately monitored for airflow and exhaust handling.
- 3.1.9. Ensure that HCW who will provide patient care have been medically cleared, fit-tested and trained for respirator use.
- 3.1.10. Provide education and refresher training in the next six weeks to HCW regarding MERS-CoV diagnosis, how to obtain specimen testing, appropriate PPE use, triage procedures including patient placement, HCW sick leave policies, and how and whom MERS-CoV cases should be reported, procedures to take following unprotective exposures (i.e., not wearing recommended PPE) to suspected MERS-CoV patients at the facility.
- 3.1.11. Assess availability of personal protective equipment (PPE) and other infection control supplies (e.g., hand hygiene supplies) that would be used for both healthcare personnel (HCW) protection and source control for infection patients (facemask on the patient).



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3.1.12. Have contingency plans if the demand for PPE or other supplies exceeds

3.1.13. Assess effectiveness of environmental cleaning procedures; provide education or refresher training for nursing and housekeeping staff.

3.2. **Managing of suspected/confirm case of MERS-CoV visiting ER:**

3.2.1. ER triage staff and coordination office shall be trained on MERS-CoV case definition.

3.2.2. The Staff nurse assign in screening room will assess the patient about cause of visiting to ER and will inform treating physician.

3.2.3. After assessment by treating physician, if the patient having criteria according to CD I, II, III and IV, the suspected will be referring directly in Isolation Room ER.

3.2.4. The staff nurse assign for the case is responsible to isolate the patient, give education for patient and visitor about cough etiquette and wear mask, and inform the Infection Control Department and Public Health.

3.2.5. Restrict patient's movement.

3.2.6. Make sure the isolation sign and PPE in place.

3.2.7. Get the contact number of family and inform Public Health.

3.3. **Managing of suspected case refer to other hospital:**

3.3.1. Patient will be admitting in isolation room.

3.3.2. Others patient with other diseases, complications and pregnant woman will be referred to Abu Arish General Hospital after informing.

3.3.3. During transporting patient to AAGH, make sure that the patient wear surgical mask.

3.4. **Admission Criteria**

3.4.1. Not all suspected MERS-CoV patients should be admitted to healthcare facilities.

3.4.2. Patients suspected to have MERS-CoV infection who have shortness of breath, hypoxemia, and/or clinical or radiological evidence of pneumonia should be hospitalized.

3.4.3. Patients with suspected MERS-CoV who have no shortness of breath, hypoxemia, or evidence of pneumonia may be cared for and



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isolated in their home.

3.5. General infection prevention and control precautions

3.5.1. **Standard Precautions** – a cornerstone for providing safe health care and reducing the risk of further infection should always be applied in all health-care setting for all patients. It includes the following:

3.5.1.1. Hand Hygiene

3.5.1.1.1. HCWs should apply “5 Moments for hand hygiene”.

3.5.1.1.2. HH includes either washing hands with anti-septic soap and water or alcohol-based waterless hand sanitizer.

3.5.1.1.3. Washed hands when they are visibly soiled.

3.5.1.1.4. The use of gloves does not eliminate the need for hand hygiene. HH is necessary after taking off gloves and other personal protective equipment (PPE).

3.5.2. Use of PPE to avoid direct contact with patients’ blood, body fluids, secretions (including respiratory secretions) and non-intact skin.

3.5.2.1. It should be guided by a risk assessment concerning anticipated contact with blood, body fluids, secretions and non-intact skin for routine patient care.

3.5.2.2. When the procedures include a risk of splash to the face and /or body, PPE should include the use of facial protection by means of either a medical mask and eye-visor or goggles, or a face shield; and a gown and clean gloves.

3.5.2.3. Respiratory Hygiene and Cough Etiquette

3.5.2.4. To prevent the transmission of all the respiratory infections in healthcare settings, including MERS-CoV and Influenza, the following infection control measures should be implemented at the first point of contact with a potentially infected person. They should be incorporated



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into infection control practices as one component of Standard Precautions.

3.5.3. Visual Alerts

3.5.3.1. Post visual alerts at the entrance to outpatient facilities (e.g., emergency rooms and clinics) instructing patients and person who accompany them (e.g., family, friends) to inform healthcare personnel of symptoms of acute respiratory illness (including fever with cough, sore throat, rhinorrhea, sneezing, shortness of breath, and/or wheezing) when they first register for care and to practice the following Respiratory Hygiene/Cough Etiquette.

3.5.3.2. Cover your mouth and nose with a tissue when coughing or sneezing

3.5.3.3. Dispose of the tissue in the nearest waste receptacle right after use

3.5.3.4. Perform hand hygiene (e.g., hand washing with non-antimicrobial soap and water, alcohol-based hand sanitizer, or anti-septic hand wash) after having contact with respiratory secretions and contaminated objects/materials.

3.5.3.5. Masking and Separation of Persons with Respiratory Symptoms.

3.5.3.6. Offer regular (medical) masks to persons who are coughing. Regular

(medical) masks may be used to contain respiratory secretions (N-95 masks are not necessary for this purpose).

3.5.3.7. When space and chair availability permit, encourage coughing persons to sit at least 1 meter away from others in common waiting areas for patients and visitors.

3.5.3.8. Should ensure the availability of materials for adhering to respiratory /Cough Etiquette in waiting areas for patients and visitors.

3.5.3.9. Provide tissue and no-touch receptacles for used tissue disposal.



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- 3.5.3.10. Provide conveniently located dispensers of alcohol-based hand sanitizer.
- 3.5.3.11. Sinks must be available, ensure that the supplies for hand washing (i.e., antiseptic soap and disposable towels) are consistently available.
- 3.5.3.12. Prevention of overcrowding in waiting and clinical areas is essential to prevent cross contamination.
- 3.5.3.13. Environmental ventilation in all areas within the health-care facility.
- 3.5.3.14. Environmental cleaning.
- 3.5.3.15. Prevention of needle-stick injury.
- 3.5.3.16. Safe waste management.

3.6. Triage for rapid identification of patients with Acute Respiratory Illness (ARI)

- 3.6.1. Clinical triage should be used early identification of all patients with ARI in the Emergency Rooms and the Clinics.
- 3.6.2. Rapid identification of patients with ARI and patients suspected of MERS-CoV infection is key to prevent healthcare associated transmission of MERS-CoV or other respiratory etiquette for source control should be promptly applied.
- 3.6.3. Identified ARI patients should be asked to wear a medical mask. They should be evaluated immediately in an area separate from the other patients. Infection control and prevention precautions should be promptly implemented.
- 3.6.4. If ARI patients cannot be evaluated immediately, they should wait in a waiting area dedicated for the ARI patients with spatial separation of at least 1 meter between each ARI patient and others.
- 3.6.5. Clinical and epidemiological aspects of the cases should be evaluated as soon as possible and the investigation should be complemented by laboratory evaluation.

3.7. Infection prevention and control when caring patients with suspected, probable, or confirmed MERS-CoV infection

- 3.7.1. Standard, contact, and airborne infection isolation (All) are



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recommended for management of hospitalized patients.

- 3.7.2. Recommendations are consistent with those recommended for coronavirus that caused Severe Acute Respiratory Syndrome (SARS). As information becomes available, these recommendations will be re-evaluated and updated as needed and the following considerations:

- 3.7.2.1. High rate of morbidity and mortality among infected patients.
- 3.7.2.2. Evidence of human-to-human transmission.
- 3.7.2.3. Poorly characterized clinical signs and symptoms.
- 3.7.2.4. Unknown modes of transmission of MERS-CoV.
- 3.7.2.5. Lack of vaccine and chemoprophylaxis.
- 3.7.2.6. Many patients required intubation, an aerosol generating procedure that requires airborne precautions

3.8. Home care for patients with MERS-Cov infection

- 3.8.1. Symptomatic cases of suspected, probable or confirmed cases are better managed in a healthcare setting. If this is not possible for any reason is not possible for any reason, alternative settings for healthcare provision may need to be considered. The same principle of care in the home environment applies to symptomatic patients not requiring or no longer requiring hospitalization. The patients and the household members should be educated on personal hygiene and basic infection prevention and control measures.
- 3.8.2. Limit contact with the ill person as much as possible.
- 3.8.3. Ensure that anyone who is at increased risk of severe disease does not care for the ill person or come into close contact with the ill person.
- 3.8.4. Perform hand hygiene following all contact with the ill person or his/her immediate environment.
- 3.8.5. Respiratory hygiene should be practiced by all, especially the ill person.
- 3.8.6. Discard materials used to cover mouth or nose after use.
- 3.8.7. The caregiver should wear a medical mask fitted tightly to the face when the same room with the ill person.
- 3.8.8. Clean frequently touched surfaces such as bedside tables, bed frame, and other bedroom furniture daily with regular household cleaners or diluted bleach solution (1 Part bleach to



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99 parts water). Clean bathroom and toilet surfaces daily with regular household cleaners or diluted bleach solution (1 part bleach to 9 parts water).

3.8.9. The symptomatic person should remain at home until satisfactory resolution of the symptoms. The decision to remove the ill person from home observation should be made based on either clinical or laboratory findings or both.

3.8.10. All household members should be considered contacts and their health should be monitored as described below.

3.8.11. For details, consult the WHO Rapid advice note on home care for patients with Middle East Respiratory Syndrome Coronavirus (MERS-CoV) infection presenting with mild symptoms and management of contacts.

3.9. Medical Waste Management

3.9.1. No special precautions are recommended; routine practices are sufficient.

3.10. Cleaning, Disinfection, and/or Sterilization of patient-care equipment and linen

3.10.1. If possible, use either disposable equipment or dedicated equipment(e.g. stethoscope, blood pressure cuffs, and thermometers). If equipment needs to be shared among the patients, cleaned and disinfect it between each patient use.

3.10.2. Reusable non-critical equipment (e.g. blood pressure cuffs, stethoscopes, pulse oximeter , commodes, bedpans, walkers, etc.) should be dedicated to use of the patient, and should be cleaned and disinfected before reuse with another patient. Single-use devices should be discarded in a hands-free waste receptacle after use.

3.10.3. Ensure that cleaning, disinfection and/or sterilization procedures are followed consistently and correctly.

3.10.4. Manage laundry, food service utensils in accordance with routine procedures.

3.11. Cleaning and disinfection of the environment

3.11.1. Hospital-grade cleaning and disinfecting agents are sufficient for environmental cleaning agents are sufficient for environmental cleaning for the MERS-CoV virus. All horizontal and frequently touched surfaces should be cleaned at least twice daily and when soiled.

3.11.2. The healthcare organization's terminal cleaning protocol for cleaning of the patient's room following discharge, transfer, or



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- discontinuation of contact and droplet precautions should be followed.
- 3.11.3. Housekeeping staff to wear protective equipment as indicated above and must be trained and made aware on the need of additional precautions.
- 3.11.4. Isolation areas should be cleaned after the rest of the ward areas and cleaning equipment should be disinfected after use.
- 3.12. **Collection and handling of laboratory specimens**
- 3.12.1. All specimens should be regarded as potentially infectious, and HCWs who collect or transport clinical specimens should adhere strictly to Standard Precautions to minimize the possibility of exposure to pathogens.
- 3.12.2. Ensure that HCWs who collect specimens wear appropriate PPE (gloves, gowns, particulate respirator, and eye protection). The specimen collection should be done in a well-ventilated single room.
- 3.12.3. Ensure that personnel who transport specimens are trained in safe handling practices and spill decontamination procedures.
- 3.12.4. Place specimens for transport in leak-proof specimens bags (secondary container) that have a separate sealable pocket for the specimen (i.e. plastic biohazard specimen bag), with the patient's label on the specimen container (primary container), and a clearly written request form.
- 3.12.5. Ensure the health-care facility laboratories adhere to appropriate bio-safety practices and transport requirements according to the type of organism being handled.
- 3.12.6. Notify the laboratory as soon as possible that the specimen is being transported.
- 3.13. **Managing bodies in Mortuary**
- 3.13.1. Deceased bodies may pose a potential infectious to those who handle them, either family members or body washers. Apply the following precautions:
- 3.13.1.1. Place the body in appropriate size body bag.
- 3.13.1.2. Body washing should be performed at the hospital morgue.
- 3.13.1.3. Morgue staff should apply hand hygiene, gloves, particulate mask (e.g N95 mask), water resistant gown, and boots/shoe cover.
- 3.13.1.4. If family members wish to the same precautions above.



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3.13.1.5. Ensure that the body bags (which are plastic) are appropriately disposed of when the body is removed.

4.0. RESPONSIBILITY:

4.1. It is the responsibility of the staff to comply in the proper management of suspected or confirmed cases of MERS-CoV.

5.0. PROCEDURE:

5.1. Key Components of Standard, Contact, and Airborne Precautions
Recommended for prevention of MERS-CoV in Hospital

COMPONENT	RECOMMENDATION(S)	COMMENTS
Patient placement	<ul style="list-style-type: none">Airborne Infection Isolation Room (AIIR)	<ul style="list-style-type: none">If an AIIR is not available, the patient should be transferred as soon as is feasible to a facility where an AIIR is available. Pending transfer, place a facemask on the patient and isolate him/her in a single-patient room with the door closed. The patient should not be placed in any room where room exhaust is recirculated without high-efficiency particulate air (HEPA) filtration.Once in an AIIR, the patient's facemask may be removed.When outside of the AIIR, patients should wear a facemask to contain secretions.Limit transport and movement of the patient outside of the AIIR to medically-essential purposes.Implement staffing policies to minimize the number of personnel that must enter the patient's room.After a potentially infectious patient leaves a room, unprotected



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		individuals, including HCP, should not be allowed in the room until sufficient time has elapsed for enough air changes to remove potentially infectious particles. More information on clearance rates under differing ventilation conditions is available www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e#tab1 .
Aerosol Generating Procedure	<ul style="list-style-type: none"> Use a combination of measures to reduce exposures from aerosol-generating procedures when performed on MERS-CoV patients. Limiting the number of HCP present during the procedure to only those essential for patient care and support. Conduct the procedures in a private room and ideally in an AIIR when feasible. Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized during and shortly after the procedure. HCP should adhere to PPE precautions in this interim guidance (i.e., gloves, a gown, and either a face shield that fully covers the front and sides of the face or goggles, and respiratory protection that is at least as protective as a fit-tested N95 filtering facepiece 	<ul style="list-style-type: none"> Although there are limited data available to definitively define a list of aerosol generating procedures, procedures that are usually included are those planned ahead of time, such as bronchoscopy, sputum induction, elective intubation and extubation; and some procedures that often occur in unplanned, emergent settings and can be life-saving, such as cardiopulmonary resuscitation, emergent intubation, and open suctioning of airways. Once the patient vacates a room where aerosol generating procedures were conducted, unprotected individuals, including HCP, should not be allowed in that room until sufficient time has elapsed for enough air changes to remove potentially infectious particles. More information on clearance rates under differing ventilation conditions is available www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e#tab1.



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	<p>respirator [e.g., powered air purifying or elastomeric respirator during aerosol-generating procedures]).</p> <ul style="list-style-type: none">Conduct environmental surface cleaning following procedures (see section below on environmental infection control).	
Personal Protective Equipment (PPE) for Healthcare personnel (HCP)	<ul style="list-style-type: none">GlovesGownsEye protection (goggles or face shield)Respiratory protection that is at least as protective as a fit-tested NIOSH-certified disposable N95 filtering face piece respirator or greater.If a respirator is unavailable, a facemask should be worn. In this situation respirators should be made available as quickly as possible.	<ul style="list-style-type: none">Recommended PPE should be worn by HCP upon entry into patient rooms or care areas for any reason (e.g., clinical care, specimen collection, environmental cleaning, etc.).Upon exit from the patient room or care area, PPE should be removed and either<ul style="list-style-type: none">Discarded, orFor re-useable PPE, cleaned and disinfected according to the manufacturer's reprocessing Instructions.Hand hygiene should be performed after removal of PPE.
Hand Hygiene	<ul style="list-style-type: none">HCP should perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves.	<ul style="list-style-type: none">Hand hygiene in healthcare settings can be performed by washing with soap and water or using alcohol-based hand rubs. If hands are visibly soiled, use soap and water, not alcohol-based hand rubs.
Environmental Infection Control	<p>Follow standard procedures, per hospital policy and manufacturers' instructions, for cleaning and/or disinfection of:</p> <ul style="list-style-type: none">Environmental surfaces	<ul style="list-style-type: none">Use EPA-registered hospital disinfectants to disinfect hard non-porous surfaces.Follow label instructions for use.



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	<ul style="list-style-type: none">and equipment❖ Textiles and laundry❖ Food utensils and dishware	<ul style="list-style-type: none">▪ Searchable EPA website of registered products: http://iaspub.epa.gov/apex/pesticides/f?p=PPLS:1.
Duration of Infection Control Precautions	<ul style="list-style-type: none">▪ At this time, information is lacking to definitively determine a recommended duration for keeping patients in isolation precautions.▪ Duration of precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities.	<ul style="list-style-type: none">▪ Factors that should be considered include: presence of symptoms related to MERS-CoV, date symptoms resolved, other conditions that would require specific precautions (e.g., tuberculosis, <i>Clostridium difficile</i>) and available laboratory information.
Monitoring and Management of Potentially Exposed Personnel	<ul style="list-style-type: none">▪ HCP who care for patients with MERS-CoV should be advised to monitor and immediately report any signs or symptoms of acute illness to their supervisor or a facility designated person (e.g., occupational health services) for a period of 14 days after the last known contact with the sick patient.▪ HCP who develop respiratory symptoms or fever after an unprotected exposure (i.e. not wearing recommended PPE at the time of contact) to a patient with MERS-CoV should<ul style="list-style-type: none">❖ not report to work or immediately stop working❖ notify their supervisor❖ implement respiratory	



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- hygiene and cough
etiquette
- ❖ seek prompt medical
evaluation
 - ❖ comply with work
exclusion until they are
deemed no longer
infectious to others.
 - For asymptomatic HCP
who had an unprotected
exposure (i.e. not wearing
recommended PPE at the
time of contact) to a
patient with MERS-CoV
 - Consider exclusion from
work for 14 days to
monitor for signs and
symptoms of respiratory
illness and fever
 - If necessary to ensure
adequate staffing of the
facility the asymptomatic
provider could be
considered for continuing
work if they wear a
facemask for source
control (i.e., limiting
transmission from
exposed HCP to other
HCP or patients),
 - The facemask should be
worn at all times while in
the healthcare facility for
14 days from the last
unprotected exposure
 - HCP continuing to work
while wearing a facemask
should be reminded that if
caring for patients under
airborne precautions, to
change the facemask to
respiratory protection that
is at least as protective as



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	<p>a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator (without an exhalation valve) (i.e., the HCP should not wear both a facemask and respirator at the same time.) When respirator use is no longer needed, the HCP should put a facemask back on for source control.</p>	
Monitoring, Management, and Training of Visitors	<ul style="list-style-type: none">Establish procedures for monitoring managing and training visitors.Limit visitors to those who are essential for the patient's wellbeing and care.Visits should be scheduled and controlled to allow for:<ul style="list-style-type: none">Screening of symptoms for acute respiratory illness before entering the hospital and upon arrival to hospitalFacilities to evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for MERS-CoV) and ability to comply with precautions<ul style="list-style-type: none">Facilities to provide instruction, before entry into the patient care area on hand hygiene, limiting surfaces touched, and use of PPE according	<ul style="list-style-type: none">Visitors who have been in contact with the MERS-CoV patient before and during hospitalization are a possible source of MERS-CoV for other patients, visitors, and staff.



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	<p>to the current facility policy while in the patients room</p> <ul style="list-style-type: none">• Facilities should consider tracking (e.g., logbook) of all visitors who enter patient rooms• Visitors should not be present during aerosol-generating procedures• Visitors should be instructed to limit their movement within the facility.	
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6.0. MATERIAL/EQUIPMENT:

- 6.1. MERS-CoV Notification form
- 6.2. Personal Protective Equipment (PPE)
- 6.3. Isolation Sign
- 6.4. Disinfectants
- 6.5. Medical Waste bin/container
- 6.6. Dead body bag (plastic) different sizes

7.0. REFERENCE:

- 7.1. Ministry of Health Guidelines on MERS-CoV (2017)
- 7.2. WHO website
- 7.3. CDC website



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8.0. APPROVALS :

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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1.0 PURPOSE:

- 1.1 Provide guidance on **COVID-2019** surveillance activities in the healthcare setting and in the community. Provide guidance on the infection control precautions for suspected and confirmed **COVID-2019** cases.
- 1.2 Enhance the detection of confirmed cases/clusters of **COVID-2019** infection and any evidence of amplified or sustained human-to-human transmission Provide guidance for rational use of resources including laboratory testing.
- 1.3 Determine clinical and epidemiological characteristics of the **COVID-2019** infection incubation period, disease spectra, risk factors, secondary attack rates, and modes of transmission.
- 1.4 Determine risk (including geographic) factors for infection with the virus.
- 1.5 Provide guidance on infection prevention and control practices to be implemented when managing suspected and confirmed **COVID-2019** cases.
- 1.6 Standardize the clinical management of **COVID-2019** patients.

2.0 DEFINITIONS:

- 2.1 A person with acute respiratory illness (fever with cough and/or shortness of breath) AND any of the following:
 - 2.1.1. A history of travel to high risk area in the 14 days prior to symptom onset.
 - 2.1.2. A close physical contact* in the past 14 days with a confirmed case of **COVID-2019** infection



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2.2. *Close contact is defined as:

2.2.1. Health care associated exposure, including providing direct care for **COVID-2019 patients**, working with health care workers infected with **COVID-2019**, visiting patients or staying in the same close environment of a **COVID-2019** patient.

2.2.2. Working together in close proximity or sharing the same classroom environment with a with **COVID-2019** patient

2.2.2.1. Traveling together with **COVID-2019** patient in any kind of conveyance

2.2.2.2. Living in the same household as a **COVID-2019** patient

2.3. Confirmed

2.3.1. Confirmed case is defined as a suspected case with laboratory confirmation of **COVID-2019** infection

3.0 RESPONSIBILITY:

3.1 Hospital control and leadership committee – hospital director Chairman

3.2 Medical director / co-chairman

3.2 Infection Control – Team

3.3 Chief of ER Department

3.5 Chief of Laboratory

3.6 Directory of Nursing

3.7 Chief of Public Health

3.8 Chief of Medical Store



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3.9 ISOLATION HEAD NURSE

3.10 FMS director

4.0 POLICY:

4.1 Triage of Suspected Case COVID-2019 or MERS-CoV.

4.1.1 The patient will be given surgical mask, hand hygiene and placed in Respiratory cases WAITING EREA , if scores met, ISO physician will assess the patient Under droplet and contact precautions.

4.1.2 If the physician advised suspects **COVID-2019 infection or MERS-CoV infection**, patient will be shifted to ISOLATION Ward. But if the ISO physician **did not suspect neither COVID-2019 nor MERS-COV** infection by our scoring systems & case definitions, patient will be shifted to normal ER

4.1.3 for vital signs Patient Assessment will be assessed by nurse and Attend physician in Isolation

4.1.4 Triage staff and cleaner will do surface disinfection of high touched areas after patient shifted, under full supervision of nurse and documented

4.1.5 ER doctor will inform the medical specialist to assess if the patient meets criteria for admission and inform Nurse Staff in ISOLATION room.

4.1.6 The visual triage nurse will ask the contact patient to go to admission office and Give information of patient..

4.1.7 The Medical specialist further assesses the patient in the isolation room and advice forward to admit or home isolate for **MERS-CoV** but **all suspected for COVID-2019** should be



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isolated and admitted for the time being until further instructions by the Infectious disease ID
OR OUR DOCTOR BY TELEMEDICINE CONSULTATION

4.1.8 contact ID consultant for further instruction

4.1.9 Infection Control measures must be implemented during handling patient placed in waiting area

4.1.10 measure Isolation and patient transfer and admission to isolation Room.

4.1.11 if there is more than one Pt. Cases Triage. Nurse should place those patients in respiratory designated waiting areas 1.3 meter

5.0 PROCEDURE:

5.1 Early recognition and source control.

5.1.1 Activation of respiratory triage and encourage HCWs to have a high level of clinical suspicion.

5.1.2 Post signage reminding symptomatic patients to alert HCWs.

5.1.3 Promotion of respiratory hygiene is an important preventative measure.

5.1.4 Suspected 2019-nCoV patients should be placed in an area separate from other patients, and additional Infection Prevention and Control IPC (droplet and contact) precautions promptly implemented.

5.2 Application of Standard Precautions for all patients

- Standard Precautions include:

5.2.1 Correct and consistent use of available PPE and appropriate hand hygiene.

5.2.2. Perform hand hygiene after contact with respiratory secretions

5.2.3 PPE effectiveness depends on adequate and regular supplies

5.2.4 Adequate staff training and specifically appropriate human behavior.



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5.2.5 Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly. Thorough cleaning of environmental surfaces with water and detergent and applying commonly used hospital level disinfectants (such as ammonia tetra H₂Pr₂) is an effective and sufficient procedure.

5.2.6 Manage laundry, food service utensils and medical waste in accordance with safe routine procedures.

5.2.7 prevention of needle-stick or sharps injury

5.2.8 Ensure the following respiratory hygiene measures:

5.2.8.1 Offer a medical mask for suspected 2019-nCoV infection for those who can tolerate it.

5.2.8.2 Cover nose and mouth during coughing or sneezing with tissue or flexed elbow for others.

5.3 Implementation of empiric additional precautions.

5.3.1 Contact and Droplet precautions for suspected 2019-nCoV infection:

In addition to Standard Precautions, all individuals, including family members, visitors and HCWs should apply Contact and Droplet precautions.

5.3.1.1 **PATIENTS SUSPECT OF COV-19** Putting patients in single room adequately ventilated if they are not available keep highly suspected covid-19 patients together in a shared room **WITH A HEPAFILTER SYSTEM OR PORTABLE DEVICES,**

ENSURE THAT

- ✓ 1.3 meters distance between the bed as minimum
- ✓ Physical separation of at least 1-meter distance should be maintained between each suspect patient and others.
- ✓ keep patients together Until a single room available as soon as possible, or a refer patient to another hospital. For covid isolation as medical coordinator protocol

5.3.1.2 **PATIENTS CONFORM OF COV-19** When single rooms are not available, cohort patients infection together (Place patient beds at least 1.3 m apart, when possible, cohort HCWs to



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exclusively care for cases to reduce the risk of spreading transmission due to inadvertent infection control breaches).

5.3.1.3 Use a medical mask with an eye/facial protection (i.e. goggles or a face shield).

5.3.1.4 Use gloves and a clean, non-sterile, long-sleeved fluid resistant gown.

5.3.1.5 Use either single use disposable equipment or dedicated equipment (e.g. stethoscopes, blood pressure cuffs and thermometers). If equipment needs to be shared among patients, clean and disinfect between each patient use (e.g. ethyl alcohol 70%).

5.3.1.6 Refrain from touching eyes, nose or mouth with potentially contaminated hands.

5.3.1.7 Avoid the movement and transport of patients out of the room or area unless medically necessary.

5.3.1.8 Use designated portable X-ray equipment and/or other important diagnostic equipment.

5.3.1.9 Ensure that HCWs who are transporting patients wear appropriate PPE as described in this section and perform hand hygiene.

5.3.1.10 Notify the receiving area of necessary precautions as soon as possible before the patient's arrival.

5.3.1.11 Routinely clean and disinfect patient-contact surfaces.

5.3.1.12 Maintain a record of all persons entering the patient's room including all staff and visitors.

5.4 Airborne precautions for aerosol-generating procedures for suspected 2019-nCoV infection:

Some aerosol generating procedures have been associated with increased risk of transmission of coronaviruses (SARS-CoV and MERS-CoV) such as tracheal intubation, non-invasive ventilation, tracheotomy, cardiopulmonary resuscitation, manual ventilation before intubation and bronchoscopy. HCWs performing aerosol-generating procedures should note the following:



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5.4.1 Use a fit tested particulate respirator (certified N95).

5.4.2 Always perform the seal-check when putting on a disposable particulate respirator (certified N95), always perform the seal-check.

5.4.3 HCW that all available types of (N95) are not fit to him should be avoided from aerosol-generating procedures or use PAPR.

5.4.4 Facial hair (beard) prevents proper respirator fit; either avoid aerosol-generating procedures or use PAPR.

5.4.5 Use eye protection (i.e. goggles or a face shield).

5.4.6 Clean, non-sterile, long-sleeved gown and gloves, if gowns are not fluid resistant, use a waterproof apron for procedures with expected high fluid volumes that might penetrate the gown.

5.4.7 Perform procedures in negative pressure rooms with at least 12 air changes per hour (ACH) and controlled direction of air flow when using mechanical ventilation.

5.4.8 Limit the number of persons present in the room to the absolute minimum required for the patient's care and support

5.5 Administrative controls

5.5.1 Establishment of sustainable IPC infrastructures and activities.

5.5.2 HCWs training; patients' care givers education.

5.5.3 Policies on early recognition of acute respiratory infection potentially due to 2019-nCoV.

5.5.4 Prevention of overcrowding especially in the emergency department.

5.5.5 Provision of dedicated waiting areas with clear signage of "Respiratory Waiting Area for symptomatic patients and appropriate placement of hospitalized patients promoting an adequate patient-to-staff ratio.

5.5.6 Provision and use of regular supplies.



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ADMINISTRATIVE POLICY PROCEDURE

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5.5.7 Monitoring of HCW compliance, along with mechanisms for improvement as needed.

5.6 Environmental and engineering controls

5.6.1 Basic health-care facility infrastructures.

5.6.2 Ensuring adequate environmental ventilation.

5.6.3 Adequate environmental cleaning in all areas within a health-care facility.

5.6.4 Terminal room cleaning at the time of discharge or transfer of patients by housekeepers to environment and surfaces. Supervision by environment health staff or nursing supervisor

5.6.5 Patient's bed , medical equipment and machine disinfection by who staff nurse assigned to the areas as terminal clean protocols and documented in IPC T.C FORM or CDC form

5.6.5 In Outbreak's Situations Terminal Clean Must Be Supervision By OCT Or IPC Staff

5.7 Collection and handling of laboratory specimens from patients with suspected 2019-nCoV

5.7.1 All specimens collected for laboratory investigations should be regarded as potentially infectious.

5.7.2 HCWs who collect or transport clinical specimens should adhere rigorously to Standard Precautions to minimize the possibility of exposure to pathogens.

5.7.3 Ensure that HCWs who collect specimens use appropriate PPE (eye protection, medical mask, long-sleeved gown, gloves).

5.7.4 The respiratory specimen should be collected under aerosol generating procedure, personnel should wear a particulate certified N95 respirator or PAPR.

5.7.5 Ensure that all personnel who transport specimens are trained in safe handling practices and spill decontamination procedures.

5.7.6 Place specimens for transport in leak-proof specimen bags with the patient's name label on the specimen container (primary container), and a clearly written laboratory request form.



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5.7.7 Ensure that health-care facility laboratories adhere to appropriate biosafety practices and transport requirements according to the type of organism being handled.

5.7.8 DO NOT use pneumatic-tube systems to transport specimens.

5.7.9 Document patient's full name, date of birth of suspected 2019-nCoV of potential concern clearly on the accompanying laboratory request form. Notify the laboratory as soon as possible that the specimen is being transported

5.8 LABORATORY DIAGNOSIS

5.8.1 Specimen collection and shipment of 2019-nCoV

All staff who will be handling the 2019-nCoV should be trained for appropriate collection, specimen storage, packaging and transportation.

5.8.2 Laboratories to perform diagnostic testing:

5.8.2.1 At the current time, samples for 2019-nCoV should be sent to Regional asir Lab and

5.8.3 Approach to sampling

5.8.3.1 Any patient meets the criteria requires collection of 2 samples at the same time.

5.8.3.2 First sample is for laboratory tests that can be performed in the hospital locally to identify common respiratory pathogens.

5.8.3.3 Second sample has to be sent to the NHL for 2019-nCoV testing.

5.8.3 Storage and Shipment of samples

5.8.3.1 Store samples at 2-8°C and ship on ice pack to general asir lab. Samples can be stored at 2-8°C for ≤48 hours, if longer storage is needed, samples should be stored at -70 °C. If sample is frozen at -70°C, ship on dry ice.

5.8.3.2 Samples can be shipped to NHL free of charge via the courier, SMSA, following appropriate regulations. The general asir lab provides a courier service for sample transportation



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and pickup locations throughout the country for collection of samples from MOH hospitals and other Health care facilities.

5.8.3.3 All specimens must be appropriately packaged and addressed to general asir lab.

5.8.3.4 Courier services are provided 7 days a week including national holidays:

5.8.3.5 The courier will package and transport the samples in accordance with Category B transportation regulations and the WHO guidance on regulations for the transport of infectious substances 2019-2020.

5.9 Reporting of suspected Cases

5.9.1 The 2019-nCoV is an emerging pathogen, which is by default a category I reportable disease that should be immediately reported. Accordingly, all healthcare facilities are obliged to report immediately any suspected 2019-nCoV case fulfilling the above case definition by calling 1937 to report a notifiable infectious disease and through Health Electronic Surveillance Network (HESN) as **acute respiratory illness unspecified**.

6.0 FORMS & EQUIPMENTS:

6.1 Attached

7.0 REFERENCES:

7.1 Novel Corona Virus (covid-19) Infection Guidelines V1.3

7.2 Middle East Respiratory Syndrome Coronavirus; Guidelines for Healthcare Professionals, 2018, v 5.1, Saudi Arabia: Ministry of Health



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INTERDEPARTMENTAL POLICY AND PROCEDURE

IPP

VERSION:2

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1. PURPOSE

- 1.1 To Whilst planning the resumption of elective surgical cases, facilities need to prioritize and ensure that stringent infection control policies and procedures are being implemented. These policies need to be monitored and reported through clinical governance systems. Incident reporting structures need to enable a rapid response mechanism to ensure adherence and compliance. These recommendations should be read with the SCDC elective surgical services guidelines

2. DEFINITION

- 2.1 NIL

3. RESPONSIBILITIES

- 3.1 All HCWs

4. PROCEDURE

- 4.1 preoperative evaluation:

4.1.1 If patients are fit for surgery, the evaluation for risk and symptoms related to COVID-19 will be conducted with confirmatory tests if symptoms are prevalent

4.1.2 The surgery should be deferred for any patients attended with fever or respiratory symptoms and further evaluation can be conducted for COVID-19

4.1.3 These Infection control precautions and recommendation are focus on patients, staff, facility and surgery :

4.1.3.1 For Patients :

- Patient must be evaluated for covid-19 before surgery using Preoperative COVID-19 checklists for elective surgery form twice:
- first time during the preoperative evaluation (at 24-72 hours before the surgery).
- Second time in the day of surgery (or day prior, surgeon's discretion).



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- On the day of surgery, patient will fill again the covid-19 questionnaire during the preoperative evaluation. if no concern, patient will go for surgery, otherwise he will be directed to the related specialty for further workup
- No accompanying family member should be permitted. If the patient has limited mobility or disabilities requiring help then one family member/care giver can be permitted. This should be confirmed prior to the admission date.
- Must wear surgical mask on the day of surgery
- Must reassess for symptoms of COVID-19

4.1.3.2 For Staff :

- Adherence to WHO five moments and COVID-19 specific recommendation for hand hygiene
- Staff should keep social distancing (minimum 1.5 m distance when possible) and use personal protective equipment (gloves, gown, surgical mask, and goggles).
- Intubation should be performed with only the necessary staff in the operating room, and staff must wear N95 masks(fitted) and eye protection.
- Delays between room re-entrance by necessary staff and between cases.
- Minimize staffing as much as possible.
- Follow the recommendation regarding the test after exposure according to the updated (Management of Healthcare Workers Exposed to COVID-19 guidelines).
- Staff should be trained in protecting themselves and patients

4.1.3.3 For Facilities:

- Immediate cleaning and disinfection of contact



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surfaces after each procedure.

- Operating/procedural rooms must meet engineering and facility standards for air exchanges.
- Protocols or flow charts for managing and isolating patients and staff suspected of or confirmed to have COVID-19 infection

4.2 Before, During and After Surgery :

4.2.1 Pre-operative :

- 4.2.1.1 Patient must be evaluated for covid-19 before surgery using Preoperative COVID-19 (Mentioned above).
- 4.2.1.2 Surgical durations should be kept short.
- 4.2.1.3 Limited number of operations per operation room block.
- 4.2.1.4 Disinfect the operating room strictly between cases with the MOH approved disinfectant, and document cleaning between cases.
- 4.2.1.5 Health Care Workers who are under training or attending OR for training purpose such as interns or medical students are not recommended to attend the OR

4.2.2 During operation :

- 4.2.2.1 Health staff must wear N95 for all aerosol generating procedures (AGP's) even if the patients were asymptomatic and COVID-19 test were negative.
- 4.2.2.2 Minimize the amount of equipment, supplies and personnel in the room to the most needed.
- 4.2.2.3 When the patient is inside the operating room minimize traffic into and out of the room; only open the door, if necessary and the theatre door should be closed with warning sign outside the door to notify other OR staff with "no entry without permission".

- 4.2.2.4 During intubating or extubating a patient allow



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only the in-charge anesthesiologist and two assistant nurses at max

4.2.3 Post-operative :

- 4.2.3.1 Allow the patient to recover in the Theatre Room.
- 4.2.3.2 Thoroughly clean and decontaminate all surfaces, screens, keyboard, cables, monitors, and anesthesia machine according to the manufacturer recommendation.
- 4.2.3.3 Attending OR staff should remove all PPE inside the theatre except the respirator or surgical mask removed outside then hand hygiene is essential.
- 4.2.3.4 Discard all unused items on the drug tray and airway trolley after each patient.
- 4.2.3.5 Apply terminal cleaning and disinfection of the operating theater according to the housekeeping policy of the hospital.
- 4.2.3.6 It is recommended to use a H2O2 fumigation machine or UV germicidal irradiation equipment in the last of day

5. FORM / EQUIPMENT

- 5.1 Patient Assessment For Elective Surgery form
- 5.2 Preoperative COVID-19 checklists for Elective Surgery form

6. ATTACHMENT

- 6.1 Elective Surgery during COVID-19 Pandemic flow chart

7. REFERENCES

- 7.1 Infection Control Precautions and Recommendations for Elective Surgeries JULY, 2020---



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8. APPROVAL

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	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Al-hazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



Form 1: Preoperative COVID-19 checklists for Elective Surgery

Date:

Time

MRN:

Name:

ID#:

Hospital:

Circle the number reflecting the patient's condition (exposure and clinical picture) and calculate the final score:

Risks for COVID-19	Score
A. Exposure Risks	
Close physical contact with suspected case* of COVID-19 in the past 14 days.	5
Close physical contact with a confirmed case* of COVID-19 in the past 14 days.	10
Working or visiting a healthcare facility.	5
B. Clinical Signs and Symptoms	
1. Fever or recent history of fever.	10
2. Cough (new or worsening).	10
3. Shortness of breath (new or worsening).	10
4. Nausea, vomiting, and/or diarrhea.	5
5. Positive lab result of COVID-19 within 2 weeks	10
6. Positive lab result of COVID-19 more than 2 weeks	5
Total Score	

* Patient or household

High risk

≥10

Low risk

<10

Staff name: _____

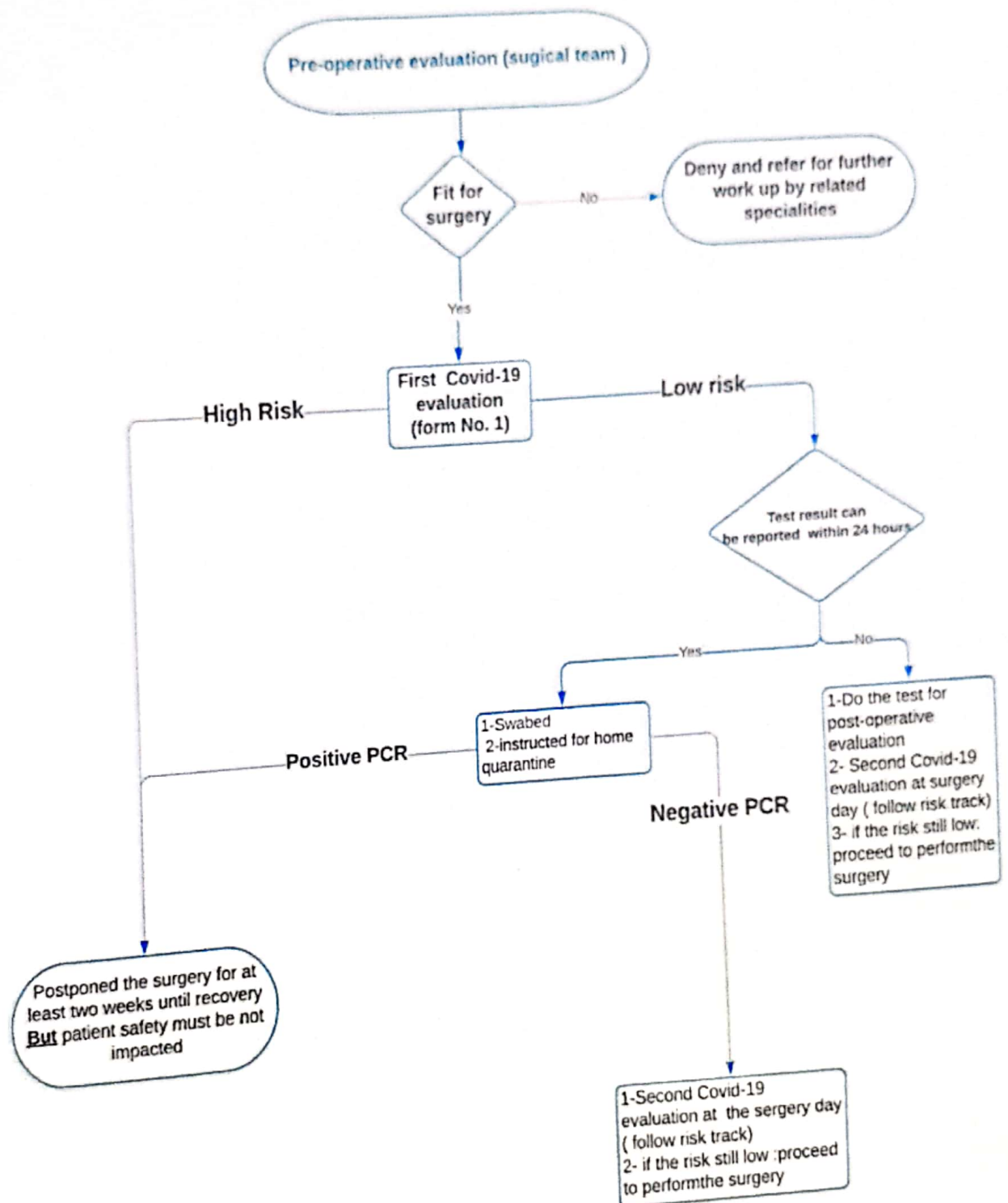
ID number: _____

Note:

The patient must be evaluated twice:

- With preoperative assessment.
- Day of surgery (or day prior, surgeon's discretion)

Elective surgery during Covid-19 Pandemic





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1. PURPOSE

- 1.1 To rendered care and provide treatment to all healthcare workers (HCWs) that are at risk of exposure to an environment in which the potential of an unknown infection hazard always exists.
- 1.2 To ensure the well-being of all healthcare workers in the hospital and protect patients from contracting communicable infections from the healthcare workers.

2. DEFINITION

- 2.1 **Health Care Worker (HCW)** – All paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air.

3. POLICY

- 3.1 Each healthcare facility must establish an employee health care program to ensure the wellbeing and safety of all workers in the institution and protect patients from contracting communicable infections from the healthcare workers.

4. PROCEDURE

4.1 Administrative procedures

- 4.1.1 The employee health program is supervised by the occupational health directorate with cooperative with infection prevention and control department and administratively under the medical director of the hospital .
- 4.1.2 During off-duty hours, weekends and national holidays, the emergency medical services department will be responsible for employee health matters that need urgent attention (e.g. post-exposure management of sharps and needle stick injuries, evaluating and treating work related injuries).

4.2 Scope of service

- 4.2.1 The employee health program will perform the following duties through Employee Health Clinic (EHC):
 - 4.2.1.1 Record keeping.
 - 4.2.1.2 Medical and Occupational history.



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- 4.2.1.3 Pre-employment screening.
- 4.2.1.4 Periodic medical examinations (and follow-up examinations when appropriate).
- 4.2.1.5 Vaccination according to most recent and updated international standards.
- 4.2.1.6 Management of needle stick injuries and body fluids exposures.
- 4.2.1.7 Post exposure prophylaxis, follow up and treatment in cases of incidents.
- 4.2.1.8 Management of work-related injuries and occupational illnesses, and referral as needed.
- 4.2.1.9 Applying work restriction rules according to international references.
- 4.2.1.10 Training.
- 4.2.1.11 Occupational health risk management.
- 4.2.1.12 Investigation or participation in the investigation of occupational incidents.
- 4.2.1.13 Treatment.

4.3 Pre-employment screening

- 4.3.1 It has two major functions:
 - 4.3.1.1 Determination of an individual's fitness for duty, including the ability to work while wearing protective equipment.
 - 4.3.1.2 Provision of baseline data for comparison with future medical data These functions are discussed below.
- 4.3.2 Please refer to appendix table IPC-29-01 Required Pre-employment tests for all new hires and volunteers.

4.4 Vaccination

- 4.4.1 Vaccination programs are therefore an essential part of infection prevention and control for HCW.
- 4.4.2 Please refer to appendix table IPC-29-02 Applying pre-employment immunizations as recommended by CDC and GCC manual 2009 recommended immunizations.

4.5 Training

- 4.5.1 A periodic regular training program for all HCWs (old and new-hire) should be executed actively including:
 - 4.5.1.1 Training of HCWs in proper infection control practices.
 - 4.5.1.2 All HCWs should receive training on standard precautions.



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4.5.1.3 Personal protective equipment, indications and proper usage.

4.5.1.4 Continuous training, at least every 6 months should be conducted to continually reinforce proper infection control practices and to inform practitioners of any new infection control procedures and safety devices.

4.5.2 The employee health program will initiate and maintain a program to monitor, manage and prevent occupational injuries related to sharp and needle-stick injuries, blood and body fluid exposure incidents, and their follow up.

4.6 Work Restrictions For Health Care Personnel

4.6.1 Please refer to appendix table IPC-29-03 Summary of suggested work restrictions for health care personnel exposed to or infected with infectious diseases of importance in health care settings, (modified from ACIP recommendations) GCC manual 2013.

4.7 The Pregnant Healthcare Worker:

4.7.1 Please refer to appendix table IPC-29-04 Pregnant healthcare workers exposed to infections Disease-causing agents that have reproductive hazards for women in the workplace (Quoted from GCC, 2013).

5. REFERENCES

5.1 Employee Health Program Policy 2018-MOH

6. APPROVAL



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**TABLE 2 SUMMARY OF SUGGESTED WORK RESTRICTIONS FOR HEALTH CARE PERSONNEL EXPOSED TO OR INFECTED WITH AN INFECTIOUS DISEASE OF IMPORTANCE IN HEALTHCARE SETTINGS
(MODIFIED FROM ACIP RECOMMENDATIONS)**

DISEASE/PROBLEM	WORK RESTRICTION	DURATION	CATEGORY
Conjunctivitis	Restrict from patient contact and contact with the patients' environment	Until discharge ceases	II
Cytomegalovirus infection	No restriction		II
Diarrheal diseases			
Acute stage (diarrhea with other symptoms)	Restrict from patient contact, contact with the patients' environment, or food handling	Until symptoms resolve	IB
Convalescent stage (Salmonella spp.)	Restrict from care of high-risk patients, such as immunocompromised patients	Until symptoms resolve; consult with employee health	IB
Diphtheria	Exclude from duty	Until antimicrobial therapy is completed and 2 cultures obtained >24 hours apart are negative	IB
Enteroviral infections	Restrict from care of infants, neonates, and immunocompromised patients and their environments	Until symptoms resolve	II
Hepatitis A	Restrict from patient contact, contact with the patients' environment, and food handling	Until 7 days after the onset of jaundice	IB
Hepatitis B	Refer to specific MOH recommendation in <i>Management of Occupational Exposure to HBV, HCV, and HIV</i> policy		
Hepatitis C	Refer to specific MOH recommendation in IPP <i>Management of Occupational Exposure to HBV, HCV, and HIV</i>		Unresolved issue
Herpes simplex			I
Genital	No restriction	Until lesions heal	IA
Hands (herpetic whitlow)	Restrict from patient contact and contact with the patients' environment		II
Orofacial	Evaluate for need to restrict from care of high-risk patients	Consult with Employee Health	

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Measles	Active	Exclude from duty	Until 7 days after the rash appears	IA
	Post-exposure (susceptible personnel)	Exclude from duty	From the 5th day after the 1st exposure through the 21st day after the last exposure and/or 7 days after rash appears	IB
Meningococcal meningitis		Exclude from duty	Until 24 hours after the start of antibiotic therapy	IA
Mumps	Active	Exclude from duty	Until 9 days after the onset of parotitis	IB
	Post-exposure (susceptible personnel)	Exclude from duty	From the 12th day after the 1st exposure through the 26th day after the last exposure or until 9 days after the onset of parotitis	II
Pediculosis		Restrict from patient contact	Until treated and observed to be free of adult and immature lice	IB
Pertussis	Active	Exclude from duty	From the beginning of catarrhal stage through the 3rd week after onset of paroxysms or until 5 days after start of effective antimicrobial therapy	IB
	Post-exposure (asymptomatic personnel)	No restriction, prophylaxis recommended; refer to policy Management of Airborne and Droplet Infectious Disease Exposure in Healthcare Workers (Chicken pox, Measles, Rubella, Mumps, MTB, <i>N. meningitis</i> , Pertussis)		II
	Post-exposure (symptomatic personnel)	Exclude from duty	Until 5 days after the start of effective antimicrobial therapy	IB
Rubella	Active	Exclude from duty	Until 5 days after rash Appears	IA
	Post-exposure (susceptible personnel)	Exclude from duty	From the 7th day after the 1st exposure through the 21st day after the last exposure and/or 5 days after rash appears	IB
Scabies		Restrict from patient contact	Until cleared by medical evaluation	IB

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Staphylococcus aureus Infection	Active, draining skin Lesions	Restrict from contact with patients, the patients' environment, and food handling	Until lesions have resolved	IB
	Carrier state	No restriction, unless personnel are epidemiologically linked to transmission of the organism		IB
Streptococcal group A infection		Restrict from patient care, contact with patients' environment, or food handling	Until 24 hours after adequate antimicrobial therapy	IB
Tuberculosis	Active disease	Exclude from duty	Until proven noninfectious by physician	IA
	Latent TB infection	No restriction	Treatment for latent TB infection	IA
Varicella	Active	Exclude from duty	Until all lesions are dry and crusted over	IA
	Post-exposure (susceptible personnel)	Exclude from duty	From the 10th day after the 1st exposure through the 21st day (28th day if VZIG given) after the last exposure	IA
Zoster	Localized, in a healthy person	Cover lesions; restrict from care of high-risk patients +	Until all lesions are dry and crusted over	II
	Generalized or localized in an immunosuppressed person	Restrict from patient contact	Until all lesions are dry and crusted over	IB
	Post-exposure (susceptible personnel)	Restrict from patient contact	From the 10th day after the 1st exposure through the 21st day (28th day if VZIG given) after the last exposure or, if varicella occurs, until all lesions are dry and crusted over	IA
Viral respiratory infections, acute febrile		Consider excluding from the care of high-risk patients ++ or from contact with their environment during community outbreaks of RSV and influenza	Until acute symptoms resolve	IB

EMPLOYEE HEALTH PROGRAM

- Unless epidemiologically linked to the transmission of infection
- Those susceptible to varicella and those who are at increased risk of complications due to varicella, such as neonates and immunocompromised persons of any age
- High-risk patients as defined by the ACIP for complications due to influenza

The system for categorizing recommendations is as follows:

1. Category IA

Strongly recommended for all hospitals and strongly supported by well-designed experimental or epidemiologic studies.

2. Category IB

Strongly recommended for all hospitals and reviewed as effective in the field, representing a consensus of hospital Infection Control Practices Advisory Committee members on the basis of strong rationale and suggestive evidence, although definitive scientific studies have not been performed.

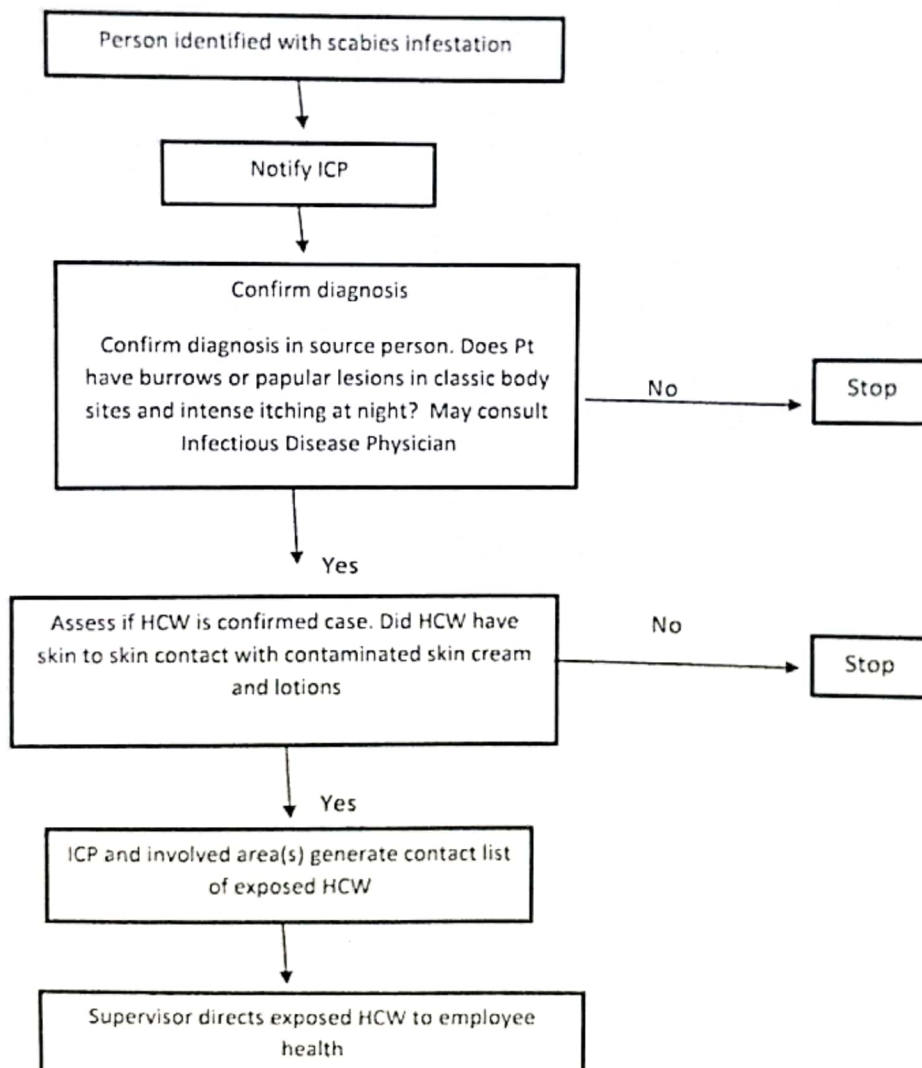
3. Category II

Suggested for implementation in many hospitals. Recommendations may be supported by suggestive clinical or epidemiologic studies, a strong theoretic rationale, or definitive studies applicable to some but not all hospitals.

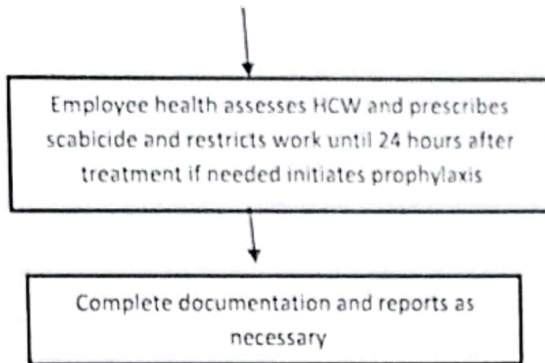
4. No recommendation or unresolved issue

Practices with insufficient evidence or consensus regarding efficacy exists.

FLOWCHART FOR SCABIES EXPOSURE



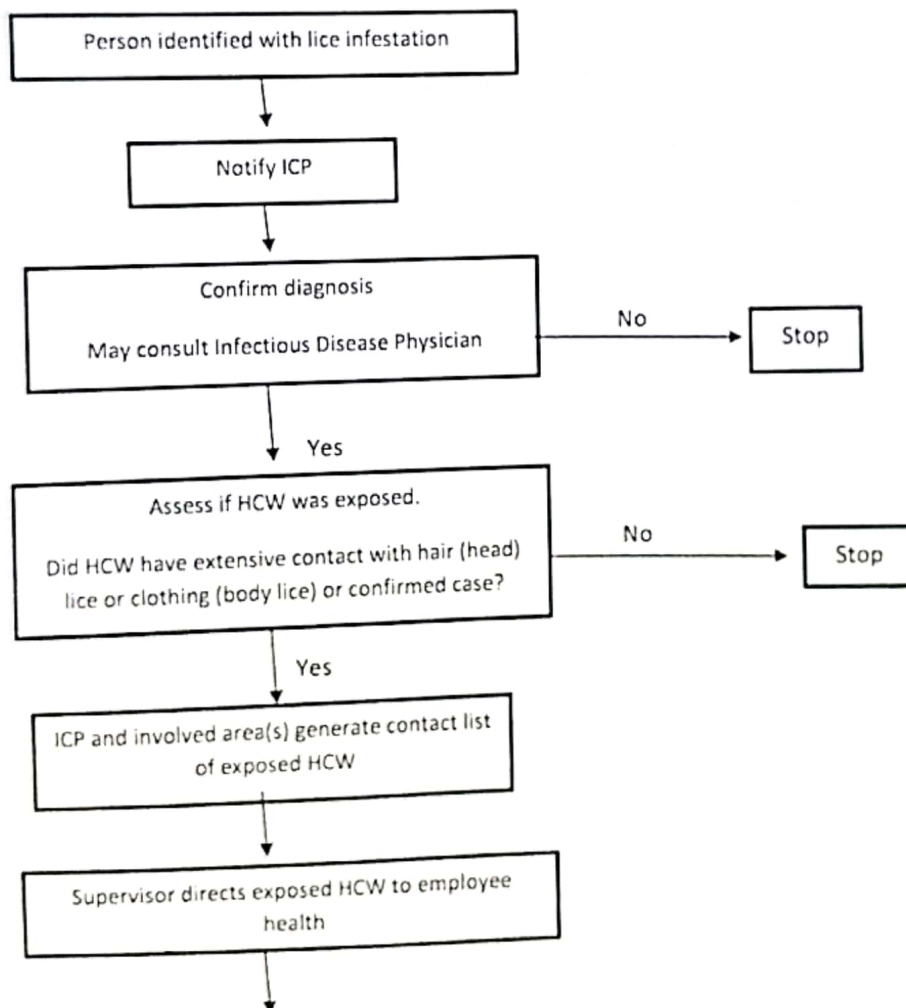
EMPLOYEE HEALTH PROGRAM



Abbreviations:

HCW	Healthcare Workers
ICP	Infection Control Practitioner
Pt	Patient

FLOWCHART FOR PEDICULOSIS (LICE) EXPOSURE



EMPLOYEE HEALTH PROGRAM

Employee health examines HCW for lice infestation. If not infested, teaches HCW about signs and symptoms. If infested, prescribes pediculocide and instruct formite disinfection of items. Restricts from work for 24 hours after

Complete documentation and reports as necessary

Abbreviations:

HCW	Healthcare Workers
ICP	Infection Control Practitioner
Pt	Patient

EMPLOYEE HEALTH PROGRAM

TABLE 3: The pregnant healthcare worker: pertinent facts to guide the management of occupational exposures to infectious agents

Agent	In-hospital source	Potential effect on fetus	Rate of perinatal transmission	Maternal screening	Prevention
Cytomegalovirus (CMV)	Urine, blood, semen, vaginal secretions, immuno-compromised or transplant patients, dialysis, day care	Classic cytomegalic inclusion disease *5% to 10% Hearing loss 10% to 15%	Primary infection 25% to 50% Recurrent infection 52% Symptomatic <5% to 15%	Routine screening not recommended Antibody is not completely protective	Efficacy of CMV immuno-globulin not established No vaccine available Standard Precautions
Hepatitis A (HAV)	Feces most commonly, blood (rarely)	No fetal transmission, transmission may occur at the time of delivery if the mother is still in the infectious phase	None	Routine screening not recommended	Vaccine is a killed virus vaccine and can safely be used in pregnancy Contact Precautions during the acute phase
Hepatitis B (HBV)	Blood, body fluids, vaginal secretions, semen	Hepatitis; early onset hepatocellular carcinoma	HB _e Ag positive 90% HBsAg positive 10%	Routine HB _s Ag testing is advised.	HBV vaccine during pregnancy Neonate: Vaccine/HBIG at birth Standard Precautions
Hepatitis C (HCV)	Blood, sexual contact	Hepatitis	5% (0 to 25%)	Anti-HCV or HCV RNA routine screening not recommended	No vaccine or immunoglobulin is available Post-exposure treatment with antiviral agents Standard Precautions
Herpes simplex virus (HSV)	Vesicular fluid, oropharyngeal and vaginal secretions	Sepsis, encephalitis, meningitis; mucocutaneous lesions; congenital malformations (rare)	Primary genital 33% to 50% Recurrent genital 1% to 2%	Antibody testing minimally useful Inspection for genital lesions during labor	Chemoprophylaxis at 36 weeks decreases shedding Standard Precautions
Human immunodeficiency virus (HIV)	Blood, body fluids, vaginal secretions, semen	Acquired immunodeficiency disease syndrome (AIDS) by 2-4 years of age No congenital syndrome	Depends on HIV viral titer If viral titer is <1000, then the rate is 2% If viral titer ≥10,000 then the rate can be up to 25%	Routine maternal screening advised (HIV ELISA, Western blot) If exposed, then testing at 3, 6 and 12 months is recommended	Antiretroviral chemoprophylaxis available for exposure, postnatal chemoprophylaxis for HIV-positive mothers and their infants Standard Precautions

EMPLOYEE HEALTH PROGRAM

PG 123

Agent	In-hospital source	Potential effect on fetus	Rate of perinatal transmission	Maternal screening	Prevention
Influenza	Sneezing and coughing, respiratory tract secretions	No congenital syndrome; influenza in the mother can cause hypoxia in fetus	Rare	None	TIV for all pregnant women during influenza season to decrease the risk of hospitalization for cardiopulmonary complications Droplet Precautions
Measles (Rubella)	Respiratory secretions, coughing	Prematurity, spontaneous abortion, congenital syndrome	Rare	Antibody test	Vaccine Airborne Precautions
Parvovirus B19	Respiratory secretions, blood, immuno-compromised patients	Fetal hydrops, stillbirth; no congenital syndrome	Approximately 25% Fetal death <10%	No routine screening; B19 DNA can be detected in serum, leukocytes, respiratory secretions, urine, and tissue specimens	No vaccine, defer care of immunocompromised patients with chronic anemia Droplet Precautions
Rubella	Respiratory secretions	Congenital syndrome *	90% in the first trimester, 40% to 50% overall	Routine rubella IgG testing in pregnancy Preconception screening recommended	Vaccine* No congenital rubella syndrome described for vaccine Droplet Precautions Contact Precautions for congenital rubella
Syphilis	Blood; lesions; fluid; amniotic fluid	Congenital syndrome *	10% to 90%, depending on the stage of maternal disease and the trimester at the time of infection	VDRL, RPR** FTA ABS	Post-exposure prophylaxis with penicillin Standard Precautions Gloves until 24 hrs of effective therapy has been completed for infants with congenital syphilis Contact Precautions when skin and mucous membrane lesions are present



EMPLOYEE HEALTH PROGRAM

Agent	In-hospital source	Potential effect on fetus	Rate of perinatal transmission	Maternal screening	Prevention
Influenza	Sneezing and coughing, respiratory tract secretions	No congenital syndrome; influenza in the mother can cause hypoxia in fetus	Rare	None	TIV for all pregnant women during influenza season to decrease the risk of hospitalization for cardiopulmonary complications Droplet Precautions
Measles (Rubella)	Respiratory secretions, coughing	Prematurity, spontaneous abortion, congenital syndrome	Rare	Antibody test	Vaccine Airborne Precautions
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EMPLOYEE HEALTH PROGRAM

PC-023

Agent	In-hospital source	Potential effect on fetus	Rate of perinatal transmission	Maternal screening	Prevention
Toxoplasmosis	No human-to-human spread; raw meat, cat feces, unwashed fruits and vegetables	Congenital syndrome*	30% to 50%; rate increases as pregnancy advances, severe disease after primary infection in first trimester	Antibody protects against disease. Routine screening not recommended in the US	Frozen or cooked meat; avoid or glove for contact with cat feces; wash fruits, vegetables, change cat litter at least once every 24 hours
Tuberculosis	Sputum; skin lesions	Neonatal tuberculosis, liver most frequently affected.	Rare	Tuberculin Skin test (TST**) QuantiFERON-TB (QFT) Chest radiograph	INH and ethambutol + rifampin for active maternal disease Airborne Precautions
Varicella-zoster virus	Respiratory secretions, vesicular fluid	Malformations (skin, limb, CNS, eye); chickenpox, zoster	Total 25% Congenital syndrome 2% (0 to 4%)	History, antibody	Vaccine* or VZIG within 96 hours of exposure if susceptible Airborne Precautions Contact Precautions



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Ministry of Health
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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

ADMINISTRATIVE POLICY PROCEDURE

APP

VERSION:2

POLICY NUMBER:	APP: IPC-030	APPLIES TO: HOSPITAL WIDE
TITLE:	VISITATION POLICY IN ISOLATION	
APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 2

1. PURPOSE

- 1.1 To reduce the risk of infection transmission of the disease.

2. DEFINITION

- 2.1 Establish procedures for monitoring managing and training visitors.
2.2 Limit visitors to those who are essential for the patient's wellbeing and care.
2.3 Educate visitors regarding standard, droplet and contact precautions

3. RESPONSIBILITY

- 3.1 NURSE INCHARGE
3.2 SECURITY
3.3 PATIENT EXPERIENCE STAFF TO EDUCATE VISITORS

4. POLICY

- 4.1 All Visits should be scheduled and controlled to allow for:
- 4.1.1 Screening of symptoms for acute respiratory illness before entering the hospital and upon arrival to hospital.
- 4.1.2 Facilities to evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for MERS-CoV) and ability to comply with precautions.
- 4.1.3 Facilities to provide instruction, before entry into the patient care area on hand hygiene, limiting surfaces touched, and use of PPE according to the current facility policy.
- 4.1.4 One visitor will be allowed for one patient at one time for maximum of 7 minutes.
- 4.1.5 Facilities should consider monitoring & tracking by security, nurse and other electronic aids (use logbook) of all visitors who enter patient rooms.
- 4.1.6 Visitors should not be present during aerosol generating procedures (AGP).
- 4.1.7 Visitors should be instructed to limit their movement within the facility.
- 4.1.8 Education concerning Respiratory Hygiene/Cough Etiquette is a useful adjunct to visitors Screening.
- 4.1.9 Limit the number of persons in the room.

5. PROCEDURE
NIL



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

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6. REFERENCES

- 6.1 Infection Prevention and Control Guidelines for Middle East Respiratory Syndrome Corona virus (MERS-CoV) Infection. 5.1 Edition may 21 2018.
- 6.2 Ministry of Health Coronavirus Disease (COVID-19) Infection Guidelines V1.2 (March 2020).

7. ATTACHMENT

NIL

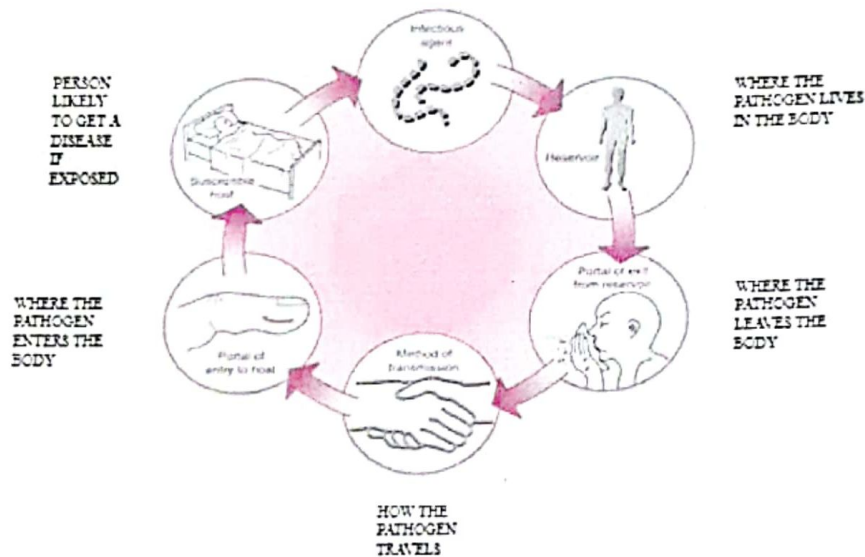
8. APPROVALS

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms.Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



General directorate of Infection Prevention and Control (MOH)

CHAIN OF INFECTION PATHOGEN



Steps Of An Outbreak Investigation

1. Verify the diagnosis; identify the agent

Describe the initial magnitude of the problem and what symptoms got the facility's attention

What diagnosis has been established?

What agent (bacterial, viral, other) has been identified?

Develop a case definition (specific criteria for a case)

A 'case definition' is a means of classifying persons as "cases" or "non-cases" based on whether or not they meet the criteria identified for the specific outbreak. A new case definition will be created for each outbreak and generally includes a combination of signs, symptoms, dates, locations, etc. that define the illness at hand. A case definition can be altered as the outbreak progresses and further information is discovered

Example: All residents who have had 3 or more loose stools in the last 24 Hours

2. Confirm that an outbreak exists

Use your case definition to find all cases

Based on your knowledge in #1, are the numbers of cases above what is endemic (usually seen) in the facility? If yes, consider that an outbreak exists

Yes

No.

Total number of cases so far

Date

Do you have an outbreak?

If yes,
proceed

If no, report will
made with
justification why
this case is not
considered an
outbreak.

3. Search for additional cases.

Encourage immediate reporting of cases (laboratory, physicians, and personnel).

Search for other cases by retrospective record review, lab reports, etc.

Total number of cases:

Date

4. Characterize the cases by person, place, and time. (Prepare a line listing and draw epidemic curve)

The 'line list' is an important tool in effective outbreak management. It is a means of collecting data that are pertinent to each individual case and the outbreak as a whole. It is essentially a database of rows and columns. Each row represents a case and each column represents descriptive factors or clinical details (i.e. date of birth, onset date, symptoms, recovery dates, etc.)

An epidemic curve: is a graph in which the cases of a disease that occurred during an epidemic are plotted according to the time of onset of illness in the cases.

5. Form a tentative hypothesis (best guess at the time).

Reservoir

Source

Mode of transmission

Review data to determine common host factors and exposures

6. *Institute preliminary control measures.*
Initiate control measures based on what you know. (Hand hygiene, isolation)

Control measures

Date of implementation
of control measures

‡Assistance needed

cohorting,etc.) Determine if you need outside assistance.

7. *Test the hypothesis.*

Many long term care facility problems never reach this stage. It may end without intervention or simple control measures may cause the problem to cease. Special epidemiologic studies may be needed and we may need to seek help.

8. *Refine the control measures.*

Add additional control measures if needed.

Control Measure Added	Date
1	
2	
3	

9. *Monitor and evaluate the control measures.*

Are control measures being used appropriately?	If Yes continue	If No ensure compliance
Evaluate control measures. Did cases cease?	If Yes continue	If no, consider additional actions

10. *Prepare and disseminate a final report.*

This form in a completed state may serve as the final report. Make the report as detailed as possible.

Date of final report:	Reported by	Reported to
	IC responsible in health facility	Hospital directorate- ¹ Directorate Health region - ² 3- directorate of infection control jazan

HAIs Outbreak Flow Chart For Dealing With An

Suspected case of outbreak clinical or

ICP verifies the diagnosis and develops case definition

1 Outbreak form

ICP notifies the hospital administration and general (directorate of infection control (GDIPC

outbreak exists ICP confirms that an

Yes

there an Is
outbreak

No

Out break form
2

ICP characterizes the cases and draw the epidemic curve using line listing

Out break form
3

hypothesis to detect ICP forms tentative the reservoir, source of outbreak and mode of transmission

Report

ICP refines the control measures and add additional measures if needed

Check list

ICP monitors and evaluates the control measures

IC team prepared daily report about the situation

4 form Outbreak

ICP prepares final report and sends it to higher authorities

ICP reports with justification to high authorities

Report

Outbreak team declares end of outbreak

Outbreak Notification Form Outbreak Form(1)

Region:-
Unit/dept.

Hospital :

Demographic data

Patient name		Age
Sex		
Address		
Telephone		Mobile

* Case identification

Symptoms onset date	
Symptoms	1
	2
	3
	4
Medical devices	
Number of positive cases	
Provisional diagnosis	

Reported by	DATE	Signature
IC responsible in health facility		

Reported to	Hospital Director
	Infection control Directorate in Jazan health
	GDIPC (MOH)

Case identification: must meet One of the following criteria

1. If the number of cases of hospital acquired infections (HAIs) exceed the facility own endemic rates.
2. If there is more than 2 cases of HAIs with the same organisms linked to the same exposure at any given time or location within 3 days.
3. If there is more than 2 transferred patients to ICUs with the same hospital acquired infections at any given time.
4. If there is one or more deaths attributed to same HAIs at any given time and locations.
5. If there is occurrence of two or more cases of reportable infectious diseases linked to the same exposure at any given time or location.
6. If laboratory data shows two or more cases of:-
 - a. Multidrug resistant organism (MDRO) isolates (isolates that are resistant to more than 2 classes of antibiotics especially MRSA)
 - b. Tuberculosis
 - c. Influenza
 - d. Varicella

Line List Of Patients Demographic Data

Outbreak Forms (2)

Ward:

[illegible]

Date:-

Risk and host factors outbreak data collection sheet

Outbreaks (3)

Patient Name	Surgical procedure	Operating room	Duration of surgery	Surgical personnel	Anaesthesia personnel	All vascular access data	Foley catheters	Chest tubes	Endotracheal tubes	Prosthetic devices	Steroids	Antibiotics	IV medications	Host** factor

**** HOST FACTORS** 1=Renal failure 2=Malignancy 3=diabetes 4=Heart disease

Fulfilled by:- IC responsible in health facility

Date:

Outbreak Final Summary Report

Outbreaks (4)

Region

Hospital

Unit / department

Demographic data

Date of outbreak onset	
Index case	
Duration of outbreak	
Causative organism	
Source of infection	
Mode of transmission	
No. of suspected cases	
No. of positive cases:-	
No. of suspected health care workers	
No. of positive health care workers:-	

Types of specimen taken and results of C&S

Types of environmental sampling and Results

Team Meeting and documentation

Communications

Measures taken to control outbreak

1	
2	
3	
4	

Outcome of outbreak

--

Recommendations to prevent further outbreak

--

Conclusions

--

Reported by: IC responsible in health facility	Date	Signature

Reported to	Hospital directorate
	Directorate Of Infection Control In Jazan
	General directorate of infection control MOH



Kingdom of Saudi Arabia
Ministry of Health
Jazan Health Directorate
AL-Harth General Hospital



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE

IPP VERSION:2	POLICY NUMBER:	IPP: IPC-031	APPLIES TO: ALL STAFF
	TITLE:	Hepatitis B Immunization for Healthcare Workers	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 3

1. PURPOSE

1.1 To provide guidelines on Hepatitis B immunization.

2. DEFINITION

NIL

3. RESPONSIBILITIES

EHC staff

4. POLICY

- 4.1 Evidence for immunity to HBV is needed for all HCWs at risk of exposure to blood or body fluids.
- 4.2 All new HCWs will be tested for Hepatitis B immunity unless a reliable document on immunity status can be provided.
- 4.3 HCWs are considered immune to HBV if they have a documented anti – HBs level > 10mIU/L at any time in the past. Even if the level had dropped afterwards, they would still be considered immune, and will not need any further doses. The drop in titer is known as anamnestic response.
- 4.4 HCWs at risk for occupational HBV exposure with no documented immunity at any time in the past are considered nonimmune regardless of the documentation of immunization and shall be immunized as outlined in this policy.

5. PROCEDURE

5.1 Pre – vaccination Testing

5.1.1 Screen all new HCWs for HBsAg and to verify HBV immune status.

5.1.2 Provide hepatitis B immunization to those HCWs who are non – immune for Hepatitis B (i.e.; those with anti – HBs < 10 mIU/L, unless they provide documentation of a completed vaccination series and anti HBs levels > 10mIU.L 1 – 2 months post vaccination.

5.1.3 Explain the risks of non – immunization to all HCWs who refuse immunization.

5.2 Administration of the Vaccine

5.2.1 Give three doses of Hepatitis B vaccine with the second and third doses at 1 and 6 months intervals, as recommended. (0, 1 , 5 month).

5.2.2 Administer intramuscularly (IM) into the deltoid muscle. Do not administer in the gluteal region.

5.3 Post – vaccination Serological Testing

5.3.1 To ensure adequate seroconversion and protection: One to two months after completing the series, the vaccine level of anti – HBs is expected to be > 10 mIU/L, and this value should be checked in any HCW with patient exposure.



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE			
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5.4 Non – responders to the First Series (If anti HBs levels are < 10 mIU/L 1 to 2 months post vaccination, take the following steps:

5.4.1 A full second series of 3 doses should be given.

5.4.2 One month after completing the second series, the vaccine level of anti – HBs is Expected to be > 10 mIU/L, and this value should be checked in any HCW with patient Exposure.

5.4.3 If the HCW remains anti – HBs negative, then he/she is considered a non – responder and should be counseled accordingly.

5.5 Counseling Non – responders

5.5.1 If all of the above measures are taken and the HCW remains anti – HBs negative, no further doses should be given.

5.5.2 The importance of standard precautions and policy should be stressed to the HCW.

5.5.3 The HCW should receive an HBsAg test; if positive, he/she should receive counseling as mentioned above. Professional duties should be reviewed along with appropriate referrals.

5.5.4 HBsAg – negative HCWs who fail to seroconvert should receive HBIG if exposed to HBsAg positive blood products or body fluid. (Refer to policy IPC-34 Management of Sharps Injury And Exposure to Blood borne Pathogens)

6. REFERENCES

6.1 GCC Infection Prevention & Control Manual 3rd Edition, January 2018

7. ATTACHMENT

7.1 NIL



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Jazan Health Directorate
AL-Harth General Hospital



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE

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8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
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	Dr. Shima	EHC doctor		9-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms.Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





DEPARTMENT OF INFECTION PREVENTION AND CONTROL
INTERDEPARTMENTAL POLICY AND PROCEDURE

IPP VERSION:2	POLICY NUMBER:	IPP: IPC-032	APPLIES TO: ALL STAFF
	TITLE:	Varicella Immunization For Healthcare Workers	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 3

1. PURPOSE:

- 1.1. To describe the criteria and conditions for administering the Varicella vaccine to HCWs and the evaluation of HCWs following Varicella Zoster (VZV) infection.

2. RESPONSIBILITY
EHC STAFF

3. DEFINITION
NIL

4. POLICY

- 4.1. Evidence for immunity to Varicella Zoster Virus (VZV) is needed for all HCWs at risk of exposure patients with chicken pox.
- 4.2. All HCWs need to be tested for VZV immunity (if available), unless a reliable document on immunity status or reliable evidence for receiving 2 doses of the VZV vaccine can be provided. Or a history from a reliable source can verify the HCW did have VZV infection in the past. This is important since other diseases may mimic VZV infection.
- 4.3. A history of Varicella infection is not considered reliable evidence of being immune and a serological test is needed(if available).
- 4.4. The VZV vaccine is alive attenuated vaccine and shall not be offered to immunocompromised individuals. Those who are non – immune will be provided the VZV vaccine unless there is a medical contraindication.

5. PROCEDURE:

5.1. Pre – vaccination Counseling

- 5.1.1. Advise all HCWs about the seriousness of Varicella infection transmitted to patients, especially the following:
- 5.1.1.1. Elderly patients.
 - 5.1.1.2. Neonates
 - 5.1.1.3. Immunocompromised patients
 - 5.1.1.4. Transplant patients.
- 5.1.2. Reliable evidence of immunity to VZV is needed; if not available, test HCWs for their serological status for varicella antibodies (if available). A HCW who is found to be immune will require no further action, and the results of varicella serology should be documented in the employee's medical records.
- 5.1.3. Provide the vaccine to those who are found to be non – immune; unless medically contraindicated.



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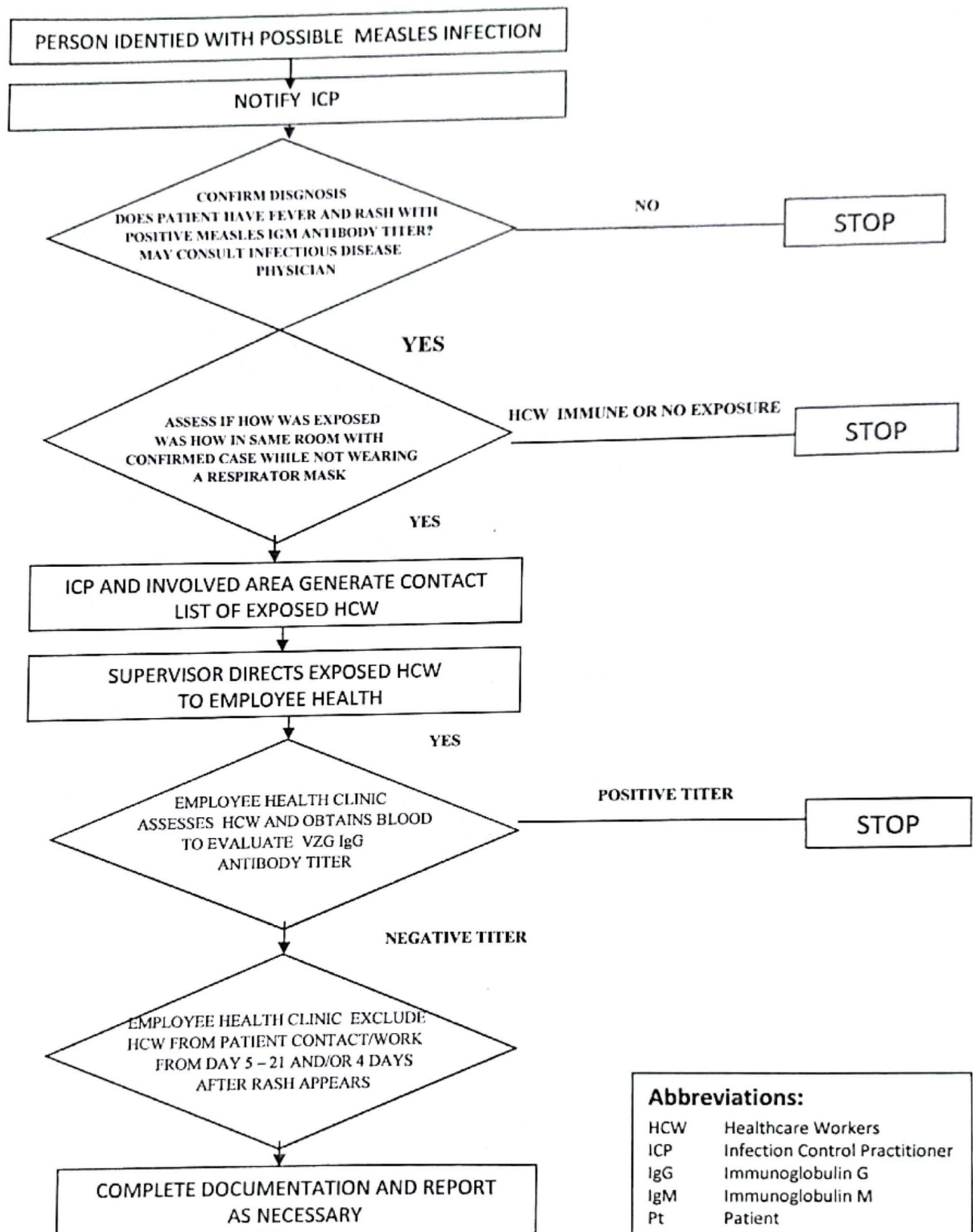
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	Mr. Fahd Najmi	Nursing Director		9-7-2021
	Dr. Shima	EHC doctor		9-7-2021
	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
Concurred	Ms.Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



APPENDIX – (IPP 033-02)
MEASLES EXPOSURE





DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE			
IPP VERSION:2	POLICY NUMBER:	IPP: IPC-033	APPLIES TO: ALL STAFF
	TITLE:	MANAGEMENT OF SELECTED AIRBORNE & DROPLET INFECTIOUS DISEASE EXPOSURE IN HEALTHCARE WORKERS	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1. PURPOSE:

- 1.1. To provide guidelines for the management of HCWs exposed to selected infectious disease transmissible via the airborne or droplet routes.

2. DEFINITION

NIL

3. RESPONSIBILITY

EHC STAFF

4. POLICY

- 4.1. The Employee Health Clinic will assess HCWs for exposure, prophylaxis, treatment, and work exclusion and will notify IPCD of the action taken. When the EHC is closed, HCW should seek medical attention in Emergency Room. Consultation may be obtained from the Infection Control Practitioners or the Director of the IPCD on call during weekends and holidays.
- 4.2. Exposed HCWs are isolated when needed home isolation in staff accommodation (Third floor – flat number 1 IN AHAH HOSTELS).
- 4.3. Management of the following conditions is outlined: Chicken Pox, Measles, Mycobacterium Tuberculosis, Meningitidis, Mumps and Rubella.

5. PROCEDURE:

5.1. **Varicella (Chicken Pox) Or Shingles Exposure (Refer To Appendix IPC-33-01)**

5.1.1. Incubation Period : Usually 14 – 16 days; range, 10 – 21 days; up to 28 days in persons who have received Varicella Zoster Immunoglobulin (VZIG).

5.1.2. Exposure criteria

5.1.2.1. Varicella: A household contacts, face to face contact for more than 5 minutes with an infected person without wearing a surgical mask, or direct contact with vesicle fluid without wearing gloves.

5.1.2.2. Shingles: Direct contact with vesicle fluid without wearing gloves.

5.1.3. Period of Communicability

5.1.3.1. Varicella: Affected persons are most contagious 1 – 2 days before and shortly after vesicles appear. Transmission can occur up to 5 days after onset of rash.



DEPARTMENT OF INFECTION PREVENTION AND CONTROL
INTERDEPARTMENTAL POLICY AND PROCEDURE

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Immunocompromised persons may be contagious as long as new vesicles are appearing.

- 5.1.3.2. Shingles: Affected persons are most contagious from 24 hours before the first Vesicle appears and up to 48 hours after the final vesicle appears.

5.1.4. Employee health

- 5.1.4.1. Assess immunity: HCW is susceptible unless he or she has a history of Varicella or has serological evidence of immunity. Consider checking Varicella IgG antibody titer to determine immune status of the HCW (if available).

- 5.1.4.2. For vaccination of HCWs against VZV, (Refer to Policy IPC-32 Varicella Immunization for HCWS).

5.1.5. Works Restrictions

5.1.5.1. Exposed:

- 5.1.5.1.1. From days 1 – 7 of exposure no restrictions is required.
5.1.5.1.2. HCWs should be excluded from duty on day 8th after 1st exposure through day 21st of last Exposure (28th day if VZIG was given after the last exposure).

- 5.1.5.2. Infected : HCW may return to work after all lesions have crusted over.

- 5.1.6. Prophylaxis : Consider giving VZIG to non – immune, immunocompromised persons or pregnant women within 96 hours of exposure.

5.2. Measles Exposure (Refer To Appendix IPC-30 -02)

- 5.2.1. Incubation Period : usually 8 – 12 days; range, 7 – 21 days
5.2.2. Exposure Criteria :Spending time in a room with an infected person without wearing a respirator. If air is recirculated, spending time in the area supplied by the air – handling system while an infected person was present or within 1 hour after the person's departure. Contact with nasal or oral secretions from an infected person or items contaminated with these secretions without wearing gloves.
5.2.3. Period of Communicability : From 4 days before the rash appears to 4 days after the rash appears, but transmission is minimal by 2 to 4 days after the rash appears.
5.2.4. Employee Health : Assess immunity; a HCW is susceptible unless he or she was born before 1957, provides serological evidence of immunity, or has two documented doses of measles vaccine. Obtain blood for IgG antibody titers as



DEPARTMENT OF INFECTION PREVENTION AND CONTROL
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IPP
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TITLE:	MANAGEMENT OF SELECTED AIRBORNE & DROPLET INFECTIONS DISEASE EXPOSURE IN HEALTHCARE WORKERS	
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needed (If available) For staff who have not received 2 doses of measles vaccine, consider initiating or completing the vaccine series.

5.2.5. Work Restriction

5.2.5.1. **Exposed :** From days 1 – 4 no restriction required. From days 5 to 21 for a single exposure or day 5 of the first exposure through day 21 of the last exposure the HCW either must not work or must have no direct patient contact or must only work with immune persons away from patient care areas.

5.2.5.2. **Infected :** HCW may return to work 4 days after developing a rash.

5.2.6. Prophylaxis : Consider giving susceptible HCWs the vaccine within 3 days or IgG within 6 days of exposure to modify severity of infection; vaccine or IG given After exposure does not change work restrictions.

5.3. Mycobacterium Tuberculosis Exposure (Refer To Appendix IPC-33-03)

5.3.1. Incubation : From 2 to 10 weeks after exposure to detection of positive Tuberculin Skin Test (TST) or Interferon – gamma release assay (IGRA); the risk of developing active disease is greatest in the first 2 years after exposure.

5.3.2. Exposure Criteria : Spending time in a room with a person who has active disease without wearing an N95 respirator; packing or irrigating wounds infected with Mycobacterium Tuberculosis (MTB) without wearing an N95 respirator.

5.3.3. Period of Communicability : Persons whose smears are AFB positive are 20 times more likely to cause secondary infections than persons who are smear negative. Children with primary pulmonary MTB are rarely contagious.

5.3.4. Employee Health : Obtain baseline TST results by doing 2 steps TST if these have not been performed recently and if the HCW was previously negative; perform post – exposure TST test at 8 to 10 weeks; if the TST test result comes out positive prescribe MTB prophylaxis. Positive IGRA result is also an indication for MTB prophylaxis.

5.3.5. Work Restrictions

5.3.5.1. Persons whose TST results and IGRA test results are positive.

5.3.5.2. **Infected :** Restricts HCWs with active MTB from duty until after They have taken 2 to 3 weeks of effective anti – tuberculosis chemotherapy and they



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have had 3 AFB – negative sputum samples taken over 8 to 24 hours (one must be an early morning specimen).

- 5.3.6. Prophylaxis : Prescribe Isoniazid 300mgs daily for 9 months (or 12 months for HIV infected persons) and Pyridoxine 20 – 40 mg daily. Consult with Infectious Disease Consultant for verification of the most appropriate prophylaxis Regimen.

5.4. **Meningococcal Disease Exposure (Refer To Appendix IPC-33-4)**

- 5.4.1. Incubation Period : usually ≤ 4 days; range, 1 – 10 days
- 5.4.2. Exposure Criteria : Extensive contact with respiratory secretions from an infected person without wearing a mask, particularly when suctioning, resuscitating or intubating.
- 5.4.3. Period of Communicability : Persons are infectious until they have taken 24 hours of effective antibiotic therapy.
- 5.4.4. Employee Health : Prescribe prophylaxis; educate exposed HCWs about the signs and symptoms of meningitis.

5.4.5. Work Restrictions :

- 5.4.5.1. **Exposed** None

- 5.4.5.2. **Infected** HCW should be restricted from work until they have taken 24 hours of effective antibiotic therapy.

- 5.4.6. Prophylaxis : Rifampicin 600 mg every 12 hours for 2 days (contraindicated in pregnancy) or Ciprofloxacin 500 mg single dose (contraindicated in pregnancy) or Ceftriaxone 250 mg IM single dose (safe during pregnancy).

5.5. **Managing Mumps Exposure (Refer To Appendix IPC-33-5).**

- 5.5.1. Incubation period : Usually 16-18 days; range, 12-25 days.
- 5.5.2. Exposure criteria : Being within 3 feet of an infected person without wearing a mask; contact with saliva or items contaminated with saliva from an infected person without wearing gloves.
- 5.5.3. Period of communicability : Patients are most communicable 48 hours before the onset of illness, and continue until 5 days after the onset of parotitis.



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

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5.5.4. Employee health : Assess immunity; an HCW is susceptible unless he or she was born before 1957, provides serologic evidence of immunity, or has one documented dose of mumps vaccine. Obtain blood for IgG antibody titers as needed. For staff who has not received two doses of mumps vaccine, consider initiating or completing the vaccine series.

5.5.5. Work restrictions

5.5.5.1. Exposed : From days 1-11, no restrictions required. Restrict from work day 12th after first exposure through day 25th of last exposure or 5 days after onset of parotitis. The HCW either must not work or must have no direct patient contact, or work only with immune persons away from patient care areas.

5.5.5.2. Infected : HCW may return to work 5 days after the onset of parotid gland swelling.

5.5.6. Prophylaxis : None; The mumps vaccine is not proven to prevent infection after exposure; mumps IG does not prevent infection.

5.6. **Managing Rubella Exposure (Refer To Appendix Ipc-33-6).**

5.6.1. Incubation period : Usually 16-18 days; range, 14-21 days.

5.6.2. Exposure criteria : Contact within 3 feet of an infected person without wearing a mask; contact with nasopharyngeal secretions from an infected person or items contaminated with these secretions without wearing gloves; contact with nasopharyngeal secretions or urine from an infant with congenital rubella without wearing gloves.

5.6.3. Period of communicability : From 7 days before the rash to 7 days after the rash appears; up to 1 year for infants with congenital rubella.

5.6.4. Employee health : Assess immunity; an HCW is susceptible unless he or she was born before 1957, provides serological evidence of immunity, or has one documented dose of rubella vaccine. Obtain blood for IgG antibody titers as needed. For staff who has not received two doses of rubella vaccine, consider initiating or completing the vaccine series.

5.6.5. Work Restrictions

5.6.5.1. Exposed : From days 1-6 no restrictions required. From 7th day after the 1st exposure through the last exposure on the 23rd day, the HCW either must not work or must have no direct patient contact or must only work with immune persons away from patient care areas.

5.6.5.2. Infected : HCW may return to work 7 days after developing rash.



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE

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5.6.6. Prophylaxis: None; the rubella vaccine does not prevent infection after exposure. IG does not prevent infection.

6. ATTACHMENTS

- 6.1. Appendix IPC-30-1 Varicella (Chicken Pox) Or Shingles Exposure
- 6.2. Appendix IPC-30-2 Measles Exposure
- 6.3. Appendix IPC-30-3 Mycobacterium Tuberculosis Exposure
- 6.4. Appendix IPC-30-4 Meningococcal Disease Exposure
- 6.5. Appendix IPC-30-5 Managing Mumps Exposure
- 6.6. Appendix IPC-30-6 Managing Rubella Exposure

7. REFERENCE:

- 7.1. GCC Infection Prevention & Control Manual, 3rd Edition, January 2018.



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL
INTERDEPARTMENTAL POLICY AND PROCEDURE

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	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:7 of 7

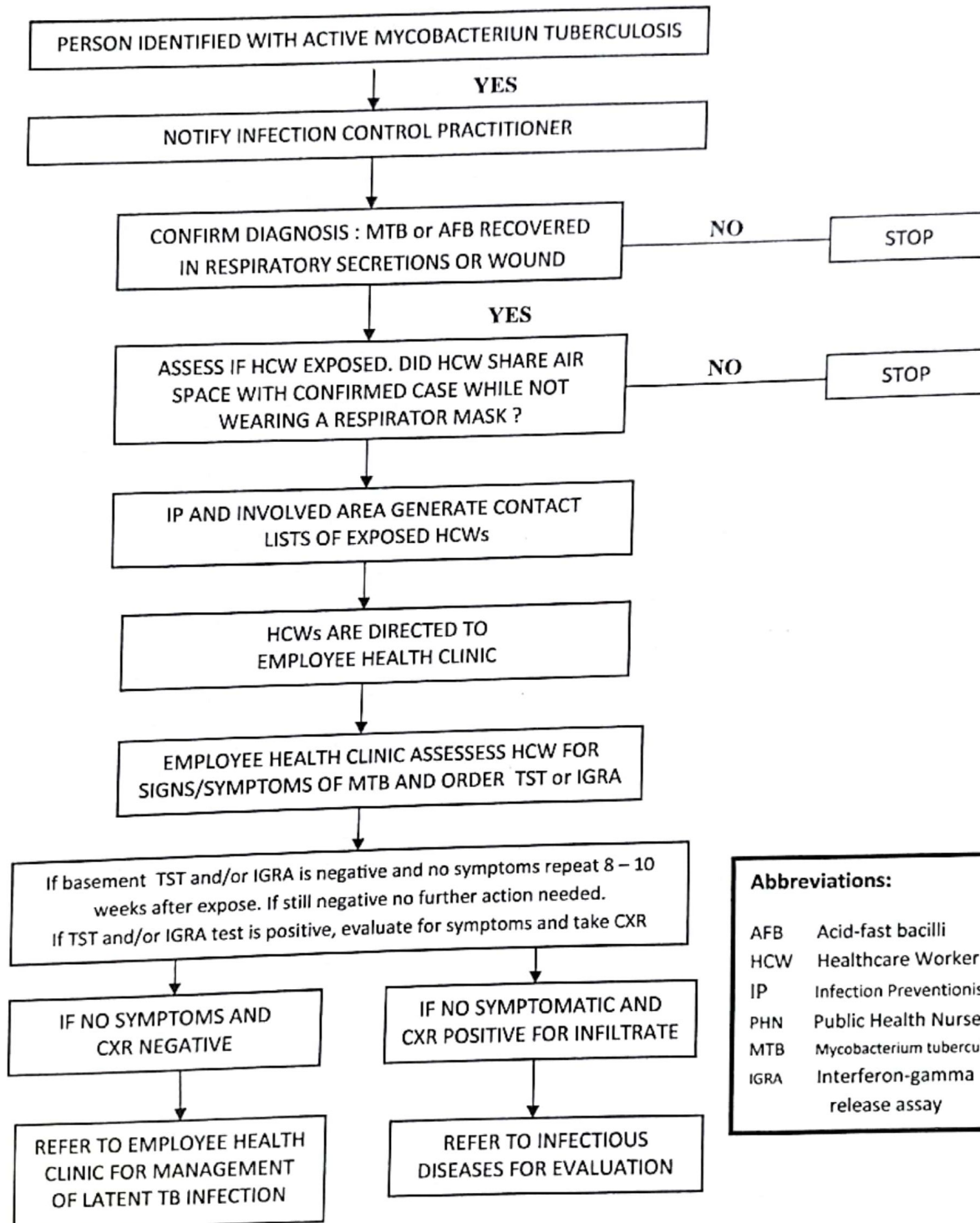
8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
	Dr. Shima	EHC doctor		9-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



APPENDIX – (IPC 033-03)

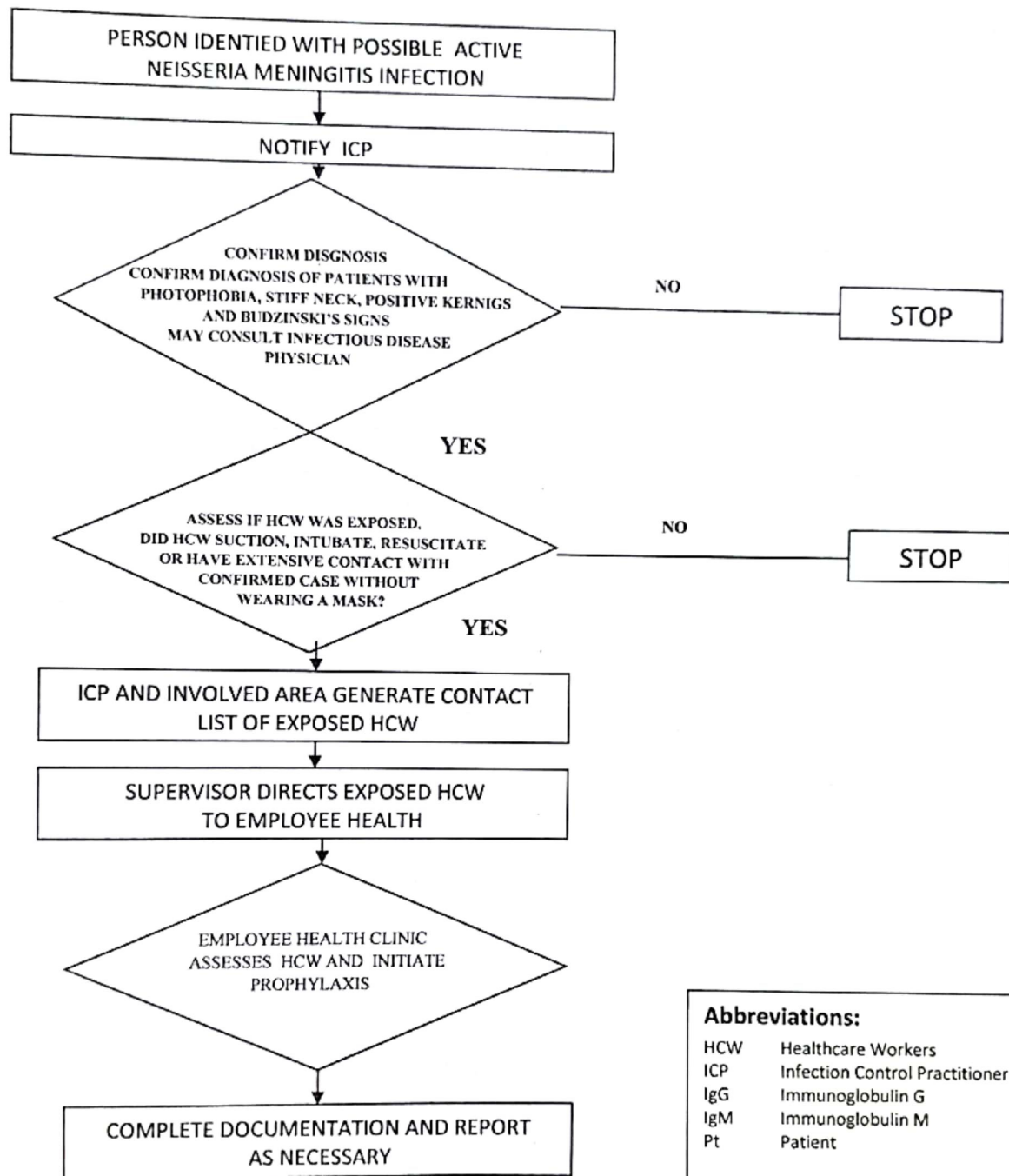
MYCOBACTERIUM TUBERCULOSIS EXPOSURE



Abbreviations:

AFB	Acid-fast bacilli
HCW	Healthcare Worker
IP	Infection Preventionist
PHN	Public Health Nurse
MTB	Mycobacterium tuberculosis
IGRA	Interferon-gamma release assay

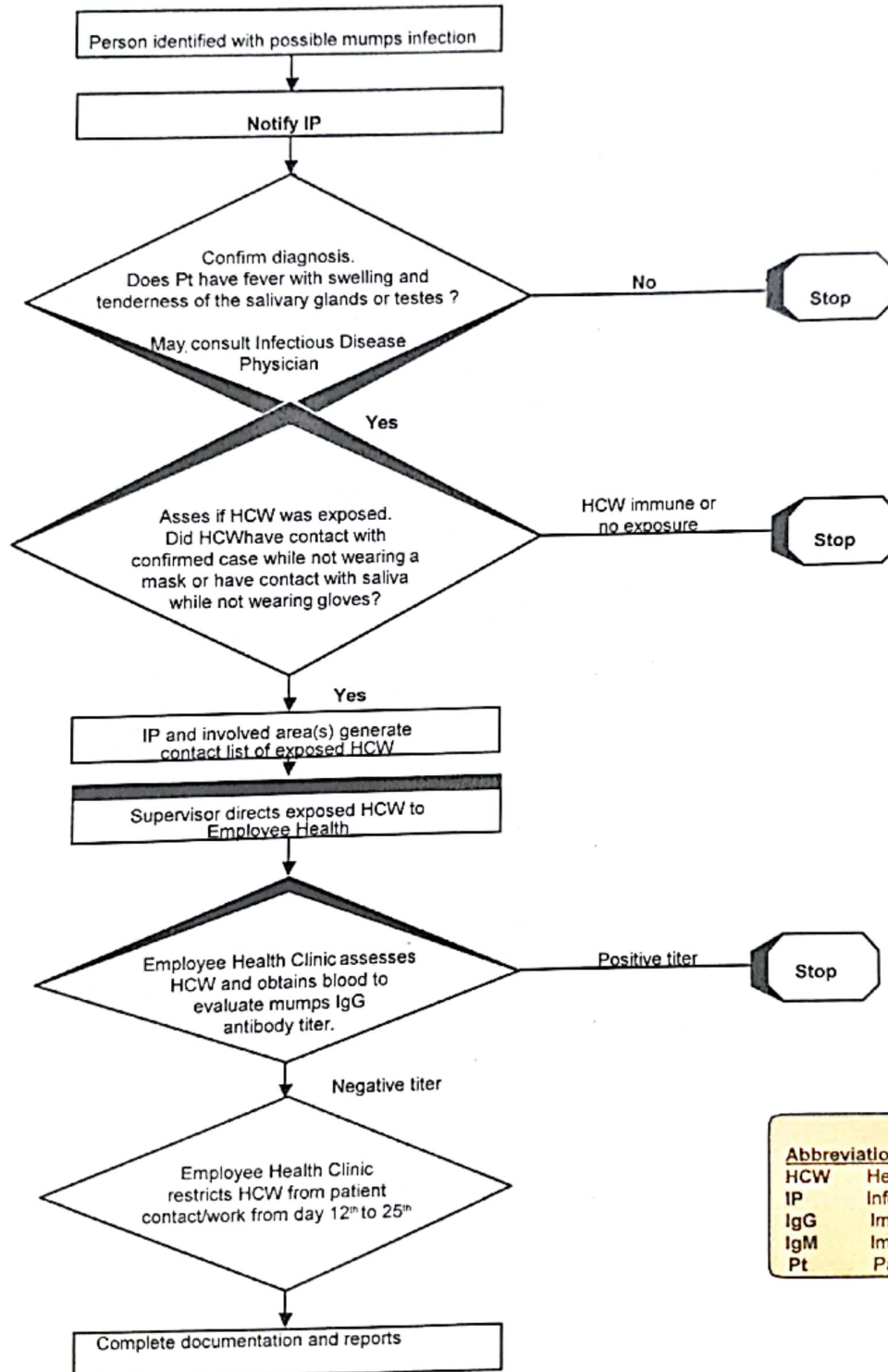
APPENDIX – (IPC 033-04)
NEISSERIA MENINGITIS EXPOSURE



Abbreviations:

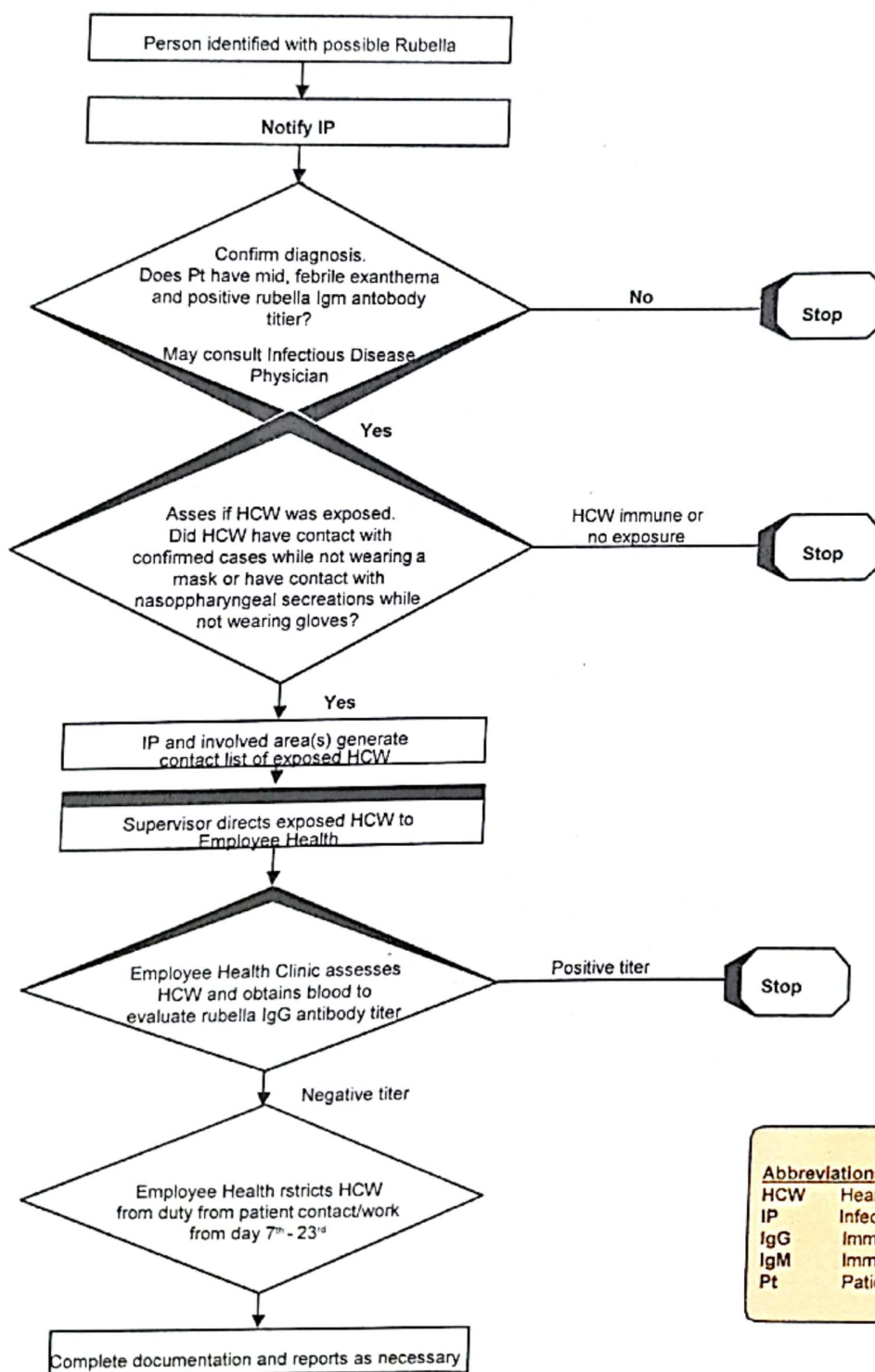
HCW	Healthcare Workers
ICP	Infection Control Practitioner
IgG	Immunoglobulin G
IgM	Immunoglobulin M
Pt	Patient

APPENDIX – (IPC 033-05)
MUMPS EXPOSURE



Abbreviations:
 HCW Healthcare Workers
 IP Infection Preventionist
 IgG Immunoglobulin G
 IgM Immunoglobulin M
 Pt Patient

APPENDIX – (IPC 033-06)
RUBELLA EXPOSURE



Abbreviations:

HCW	Healthcare Workers
IP	Infection Preventionist
IgG	Immunoglobulin G
IgM	Immunoglobulin M
Pt	Patient

Table IPC-34-01 - Post-exposure management of health-care personnel after occupational percutaneous and mucosal exposure to blood and body fluids, by health-care personnel Hep B vaccination and response status

Health-care personnel status	Post-exposure testing		Post-exposure prophylaxis		Post-vaccination serologic testing
	Source patient (HBsAg)	HCP testing (anti-HBs)	(HBIG) Hepatitis B immunoglobulin	Vaccination	
Documented responder after complete series (≥3 doses)	No action needed				
Documented non-responder after 6 doses	Positive/unknown	—	HBIG x2 separated by 1 month	—	No
	Negative	No action needed			
Response unknown after 3 doses	Positive/unknown	<10mIU/mL	HBIG x1	Initiate revaccination	Yes
	Negative	<10mIU/mL	None		
	Any result	≥10mIU/mL	No action needed		
Unvaccinated/incompletely vaccinated or vaccine refusers	Positive/Unknown	—	HBIG x1	Complete vaccination	Yes

(CDC, 2013)



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE

IPP VERSION:2	POLICY NUMBER:	IPP: IPC-034	APPLIES TO: ALL STAFF
	TITLE:	Management of Sharps Injury and Exposure to Blood borne Pathogens	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1. PURPOSE

- 1.1 To provide guidelines to prevent infection from blood and body fluid spillages in all hospital areas.

2. RESPONSIBILITY

EHC STAFF

3. DEFINITION

- 3.1 **Mucous membrane** (splash to eye or mouth/nose)..

4. POLICY

- 4.1 The Infection Control Program maintains policy for occupational exposure to protect the staff from possible infection during their course of duty.

5. PROCEDURE

- 5.1 First aid : if you experienced a needle stick or sharps injury or were exposed to blood or other body fluid of patient during the course of your work , immediately follow these steps:

5.1.1 Percutaneous injuries:

- 5.1.1.1 Do not press the injured site. Encourage bleeding from the puncture wound by keeping it low.

- 5.1.1.2 Wash the site with soap and water.

- 5.1.1.3 Apply antiseptic on the puncture wound and cover with occlusive dressing.

5.1.2 Mucous Membrane and non-intact skin exposure:

- 5.1.2.1 Splash water to the nose, mouth, or non-intact skin.

- 5.1.2.2 Irrigate eyes with clean or sterile water or saline.

- 5.1.2.3 Flush site for 10 minutes

5.1.3 Inform the unit Charge.

- 5.1.3.1 The unit Charge will make sure that the Occupational Exposure Report Form (OERF) is completely filled by the exposed employee with all the details requested before informing the unit supervisor or the general supervisor during evening and night shifts.

- 5.1.3.2 The Supervisor will be responsible in allocating staff to take over the responsibilities of the injured employee while he/she seeks medical attention.



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- 5.2 The OERF will be taken by exposed employee to Employee Health Clinic during working hours or ER during afterhours and on weekends and holidays.
- 5.3 The circumstances of the exposure and post exposure management will be documented on the OEF and in the medical record file of the employee.
- 5.4 Screening and risk assessment of the employee and the source patient will be done according to guidelines as follows:
- 5.4.1 **The source individual blood should be tested as soon as possible to determine :**
- 5.4.1.1 HBV (HBsAg, HBsAb, anti-HBc)
- 5.4.1.2 HCV (anti-HCV)
- 5.4.1.3 HIV (HIV test) serological status.
- 5.4.1.4 When the source individual is already known to be infected with HCV or HIV , testing the source needed not be repeated.
- 5.4.2 **The exposed HCWs blood should be tested for :**
- 5.4.2.1 HBV (HBsAg, HBsAb,)
- 5.4.2.2 HCV
- 5.4.2.3 HIV
- 5.4.3 **Recommended prophylaxis for exposure to Hepatitis B virus**
- 5.4.3.1 **Please Refer Table IPC-34-01:** Post-exposure management of health-care personnel after occupational percutaneous and mucosal exposure to blood and body fluids, by health-care personnel Hep B vaccination and response status
- 5.4.4 **Recommended management and prophylaxis for exposure to Hepatitis C virus:**
- 5.4.4.1 persons exposed to an HCV-positive source should have the following baseline and follow-up testing
- Baseline testing for anti-HCV, HCV RNA AND ALT
 - Follow-up testing for HCV RNA 4 TO 6 weeks after exposure.
 - Follow-up testing for anti-HCV, HCV RNA and ALT 4 to 6 months after exposure.
 - No post-exposure prophylaxis is currently recommended for HCV.
- 5.4.5 **Recommended HIV post exposure prophylaxis for HCWs:**
- 5.4.5.1 According to the jazan public health circular on 25 January 2017.
- The physician will evaluate the HCWs condition and order the following prophylaxis medicine:
 1. Truvada ONE TAB for 4 weeks



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE

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2. RALTIGRAVIR BID for 4 weeks

- Communicate with ID Dr.Mohmmad AL-Hazmei mobile number 0560001195 .

ATTACHMENT

6.1 TABLE OF Prophylaxis For Exposure To Hepatitis B Virus

REFERENCE

- 5.1 GCC Manual for Infection Control, 3rd Edition (2018)
- 5.2 Employee Health Program Policy 2018-MOH

APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
	Dr. Shima	EHC doctor		9-7-2021
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	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE			
IPP VERSION:2	POLICY NUMBER:	IPP: IPC-035	APPLIES TO: ALL STAFF
	TITLE:	TUBERCULIN SKIN TESTING	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 6

1. PURPOSE

- 1.1.To describe the procedure on how to administer and interpret the Mantoux tuberculin skin test (TST) used to diagnose of latent tuberculosis infection (LTBI) for pre-employment purposes and as part of post-exposure evaluation of employees.

2. DEFINITIONS

NIL

3. RESPONSIBILITY

EHC STAFF

4. POLICY

4.1. TST testing is used for:

- 4.1.1. Persons at high risk for TB exposure or infection.
- 4.1.2. Persons at high risk for TB disease once infected.
- 4.1.3. To identify infections in asymptomatic persons.
- 4.1.4. To establish baseline TST results for all new employees.

4.2. All new hires or new volunteers should undergo baseline testing for tuberculosis using Tuberculin Skin Testing (TST). There are two types of testing for TB in healthcare workers:

- 4.2.1. Initial baseline testing upon hire.
- 4.2.2. Annual or serial screening: determined by risk assessment of the healthcare facility and activity.

4.3. Pre-employment screening:

- 4.3.1. Question candidates regarding past positive test results prior to the actual planting of the TST.
- 4.3.2. Exclude persons who have had the following from testing:
 - 4.3.2.1. Live vaccine administered within the past 3 weeks or on the same day as the TST because live-virus vaccines may cause a false negative reaction.
 - 4.3.2.2. Current febrile illness.
 - 4.3.2.3. Smallpox vaccination within the past month.
 - 4.3.2.4. Documented positive PPD.

5. PROCEDURES :

5.1. Testing for Latent TB Infection:

- 5.1.1. The Tuberculin Skin Test (TST) detects individuals infected with Mycobacterium tuberculosis. The skin test is administered intradermal using the Mantoux technique



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE

IPP VERSION:2	POLICY NUMBER:	IPP: IPC-035	APPLIES TO: ALL STAFF
	TITLE:	TUBERCULIN SKIN TESTING	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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by injecting 1.0 ml containing 5 TU of purified protein derivative (PPD) solution. If a person is infected, a delayed-type hypersensitivity reaction is detectable 2 to 8 weeks after infection. The reading and interpretation of TST reactions should be conducted within 48 to 72 hours of administration by trained healthcare professionals.

- 5.1.2. Equipment and materials 1 cc tuberculin syringe, 26- or 27-gauge needle, ½ inch (16 mm) long, alcohol swabs and a measuring tool marked in millimeters.
- 5.1.3. Administration: The Mantoux test is the recommended TST. It is administered by injecting 1.0 ml containing 5 TU of purified protein derivative (PPD) solution intradermal into the volar surface of the forearm using a 27-gauge needle with a tuberculin syringe.
- 5.1.3.1. Obtain results of all previous TSTs. Ask the patient to describe what the test area looked like 2 to 3 days after administration; obtain documentation.
- 5.1.3.2. Avoid areas of skin with veins, rashes, or excess hair.
- 5.1.3.3. Cleanse hands with alcohol hand rub.
- 5.1.3.4. Cleanse the area with an alcohol swab, allowing the area to dry.
- 5.1.3.5. Clean the rubber top of vial before drawing up solution.
- 5.1.3.6. Inject the entire antigen just below the surface of the skin on the volar surface of the forearm, forming a 6-10 mm wheal (a pale, raised area with distinct edges; has orange peel-like appearance and does not disappear immediately).
- 5.1.3.7. Avoid covering the area with a bandage or applying pressure to the injection site.
- 5.1.3.8. If minor bleeding occurs, dab the injection site with a cotton swab.
- 5.1.3.9. If no wheal forms, or if a wheal forms that is less than 6 mm, the test should be repeated immediately, approximately 2 inches from the original site or on the other arm.
- 5.1.3.10. Record the date, time, and location of the TST.
- 5.1.3.11. Instruct the patient not to scratch the site but to use a cool compress to relieve any itching or swelling.
- 5.1.3.12. Give a written appointment card for TST reading. Inform the patient of the importance of returning for a reading of the TST within 48 to 72 hours (2 to 3 days).
- 5.1.3.13. Provide written information about the TST (a pamphlet or brochure).
- 5.1.4. Measurement:
- 5.1.4.1. Measure the induration (hard bump) rather than the erythema.
- 5.1.4.2. Palpate the area with the fingertips, measuring the diameter of induration perpendicular to the long axis of the arm.



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY AND PROCEDURE

IPP VERSION:2	POLICY NUMBER:	IPP: IPC-035	APPLIES TO: ALL STAFF
	TITLE:	TUBERCULIN SKIN TESTING	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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- 5.1.4.3. Use a ballpoint pen to mark the edges of the induration.
- 5.1.4.4. Use a tuberculin skin test ruler or a ruler with millimeter marks to measure the distance between the two points.
- 5.1.5. Recording and documentation:
- 5.1.5.1. Record the date that the TST was administered.
- 5.1.5.2. Record the brand name of the PPD solution, lot number, manufacturer, and expiration date in the patient's records.
- 5.1.5.3. Record results in millimeters of induration (0 mm if there is no induration) rather than as positive or negative.
- 5.1.5.4. Record the date and time of reading and the name of the person reading the TST.
- 5.1.5.5. Provide the patient and ordering physician with written documentation.
- 5.1.6. Storage and handling:
- 5.1.6.1. PPD solution must be kept refrigerated at 36–46°F.
- 5.1.6.2. Avoid fluctuations in temperature; do not store in the refrigerator door.
- 5.1.6.3. Syringes must be filled immediately prior to administration.
- 5.1.6.4. Store and transport the tuberculin in the dark as much as possible and avoid exposure to light.
- 5.1.7. Notes:
- 5.1.7.1. The TST should not be performed on a person who has a documented history of either a positive TST result or treatment for TB disease.
- 5.1.7.2. TST is contraindicated only for persons who have had a severe reaction (e.g. necrosis, blistering, anaphylactic shock, or ulcerations) to a previous TST.
- 5.1.7.3. TST results should only be read and interpreted by a trained healthcare professional. Patients or family members should not be relied upon to measure TST results.
- 5.1.7.4. TB disease must be ruled out before initiating treatment for Latent Tuberculosis Infection (LTBI) to prevent inadequate treatment of TB disease.



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5.2. Table 1: TST interpretation:

TST reaction induration size	≥ 5mm induration	≥10 mm of induration	≥15 mm of induration
Considered positive in	1. HIV-infected persons 2. Recent contacts of infectious TB cases. 3. Persons with fibrotic changes on chest radiograph consistent with prior TB. 4. Organ transplant recipients 5. Those who are immunosuppressed for other equivalent of ≥ 15 reasons (taking an mg/day of prednisone for 1 month or more or taking TNF-α antagonists).	1. Recent immigrants (within last 5 years) from high-prevalence countries. 2. Injection drug users. 3. Residents or employees of high-risk congregated settings (prisons, jails, long term care facilities for the elderly, hospitals and other healthcare facilities, residential facilities for patients with AIDS, and homeless shelters). 4. Mycobacteriology laboratory personnel. 5. Persons with the clinical conditions previously mentioned. 6. Children younger than 4 years of age 7. Infants, children, or adolescents exposed to adults at high risk for TB disease.	1. Persons with no risk factors for TB

5.3. Chest Radiograph:

5.3.1. Chest radiographs help differentiate between LTBI and pulmonary TB disease in individuals with positive TST results.

5.3.1.1. For TST-positive individuals:

5.3.1.1.1. Clinical evaluation to exclude active tuberculosis:

5.3.1.1.1.1. Order chest radiography as part of a medical evaluation for a person who has a positive TST.

5.3.1.1.1.2. Determine baseline CBC and liver function test (LFT).

5.3.1.1.2. Refer to the primary care consultant for evaluation and possible prophylaxis. After baseline testing, routine periodic retesting is



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recommended for persons who had abnormal initial results and other persons at risk for hepatic disease.

5.3.1.1.3. At any time during treatment, whether or not baseline tests were done, laboratory testing is recommended for patients who have symptoms suggestive of hepatitis (e.g., fatigue, weakness, malaise, anorexia, nausea, vomiting, abdominal pain, pale stools, dark urine, and chills) or those who have signs of jaundice. Patients should be instructed at the start of treatment and at each monthly visit to stop taking treatment and to seek medical attention immediately if symptoms of hepatitis develop and not to wait until a clinic visit to stop treatment.

5.4. Special Considerations during Pregnancy:

5.4.1. Consider immediate treatment for LTBI if the woman is HIV-infected or has had recent contact with a TB case and monitor the patient.

5.4.2. In the absence of risk factors, wait until after the woman has delivered to avoid administering unnecessary medication during pregnancy.

5.4.3. INH administered daily is the preferred regimen.

5.4.4. Supplementation with 50 mg pyridoxine (vitamin B6) is recommended.

5.5. Table 4: Treatment Regimens

Isoniazid	Adult: 5 mg/kg Children: 10-20 mg/kg Maximum dose: 300 mg	Daily x 9 months
Or		
Rifampin	Adults: 10 mg/kg Children: 10-20 mg/kg Maximum dose: 600 mg	Daily x 4 months



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6. REFERENCE

GCC MANUAL 2018

7. ATTACHMENT

NIL

8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
	Dr. Shima	EHC doctor		9-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		20-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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ADMINISTRATIVE POLICY AND PROCEDURE			
APP VERSION:2	POLICY NUMBER:	APP: IPC-036	APPLIES TO: HOSPITAL WIDE
	TITLE:	MANAGEMENT OF OUTBREAKS	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1. PURPOSE

- 1.1 To provide guidelines to manage an infectious disease outbreak in the hospital, including early identification, initiation of appropriate control/containment measures to prevent the spread, and assigned responsibilities.

2. DEFINITION

- 2.1 NIL

3. POLICY

- 3.1 Hospital should have a specific set of actions or guidelines planned in advance to coordinate activities during an outbreak of communicable or infectious diseases.

4. RESPONSIBILITY

- 4.1 OUTBREAKS TEAM

5. PROCEDURE

- 5.1 Steps Of An Outbreak Investigation:

- 5.1.1 Verify the diagnosis; identify the agent

- 5.1.1.1 Describe the initial magnitude of the problem and what symptoms got the facility's attention.

- 5.1.1.2 What diagnosis has been established?

- 5.1.1.3 What agent (bacterial, viral, other) has been identified?

- 5.1.1.4 Develop a case definition (specific criteria for a case)

- 5.1.1.5 A 'case definition' is a means of classifying persons as "cases" or "non-cases" based on whether or not they meet the criteria identified for the specific outbreak. A new case definition will be created for each outbreak and generally includes a combination of signs, symptoms, dates, locations, etc. that define the illness at hand. A case definition can be altered as the outbreak progresses and further information is discovered Example: All residents who have had 3 or more loose stools in the last 24 Hours

- 5.1.2 Confirm that an outbreak exists

- 5.1.2.1 Use your case definition to find all cases

- 5.1.2.2 Based on your knowledge in 4.1.1, are the numbers of cases above what is endemic (usually seen) in the facility? If yes, consider that an outbreak exists.

- 5.1.2.3 Do you have an outbreak? If yes, proceed and used outbreak form No.1 and inform hospital administration and Directorate Of



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Infection Control In Jazan. If no, report will made with justification why this case is not considered an outbreak.

5.1.3 Search for additional cases.

5.1.3.1 Encourage immediate reporting of cases (laboratory, physicians, and personnel). Search for other cases by retrospective record review, lab reports, etc.

5.1.4 Characterize the cases by person, place, and time. (Prepare a line listing and draw epidemic curve)

5.1.4.1 The 'line list' is an important tool in effective outbreak management. It is a means of collecting data that are pertinent to each individual case and the outbreak as a whole. It is essentially a database of rows and columns. Each row represents a case and each column represents descriptive factors or clinical details (i.e. date of birth, onset date, symptoms, recovery dates, etc.)

5.1.4.2 An epidemic curve: is a graph in which the cases of a disease that occurred during an epidemic are plotted according to the time of onset of illness in the cases.

5.1.4.3 Use outbreak forms No.2 by IC responsible in hospital

5.1.5 Form a tentative hypothesis (best guess at the time).

5.1.5.1 Reservoir

5.1.5.2 Source

5.1.5.3 Mode of transmission

5.1.5.4 Review data to determine common host factors and exposures.

5.1.5.5 Use outbreak form No.3 by IC responsible in hospital

5.1.6 Institute preliminary control measures.

5.1.6.1 Initiate control measures based on what you know. (Hand hygiene, isolation)

5.1.6.2 Date of implementation of control measures

5.1.6.3 Assistance needed? cohorting, etc.) Determine if you need outside assistance.

5.1.7 Test the hypothesis.

5.1.7.1 Many long term care facility problems never reach this stage. It may end without intervention or simple control measures may cause the problem to cease. Special epidemiologic studies may be needed and we may need to seek help.

5.1.8 Refine the control measures.

5.1.8.1 Add additional control measures if needed.

5.1.9 Monitor and evaluate the control measures.

5.1.9.1 Are control measures being used appropriately? If Yes continue If



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No ensure compliance

5.1.9.2 Evaluate control measures. Did cases cease? If Yes continue If no, consider additional actions.

5.1.10 Prepare and disseminate a final report.

5.1.10.1 Make the final report as detailed as possible.

5.1.10.2 Use outbreak form No. 4 and reported by IC responsible in hospital .

5.1.10.3 Reported to :

- Hospital Directorate through email to (giz-hos-hh@moh.gov.sa)
- Directorate Of Infection Control In Jazan through email to (giz-phcc-afi@moh.gov.sa)
- Infection control committee .

5.2 Activity and Responsible Person(s) :

Activity	Responsible Person(s)
Notify the hospital director and directorate Of Infection Control In Jazan .	Infection Control coordinator
Identify patient and healthcare worker contacts of cases.	ICP, Nurse Manager/Designee
Identify cases, verify the diagnosis, and search for additional cases.	Attending Physician(s), Nurse Manager/Charge Nurse, ICP, Employee Health Clinic, Microbiology Laboratory
Conduct epidemiological investigation and institute isolation and barrier precautions to assess source(s), pathogen(s) and the mode of transmission.	ICP
Notify Microbiology Laboratory of need for diagnostic tests.	ICP
Establish an ad-hoc committee to manage the potential outbreak	Infection Control supervisor , infection control staff, director of Nursing Services, medical director, microbiology, public health and others as deemed necessary
Advise Hospital Administration.	Infection Control supervisor



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Inform and assess patient contacts for prophylaxis.	Attending Physician, infection control staff, Director of Infection Control/Designee
Direct HCWs to the Employee Health Clinic for assessment.	Infection control staff (for physicians), Nurse Manager (for other healthcare workers)
Assess HCWs for prophylaxis and work exclusion.	Employee Health Clinic.
Designate infected and non-infected cohort areas as required. Move infected cohort to an alternate location as determined by census, patient status, and admitting needs.	Infection Control supervisor, ICP, Director of Nursing Services, Department Chairman
Declare unit/ward closure if necessary.	Infection Control supervisor in consultation with Hospital Administration and Department Chairman and Director of Nursing Services

6. ATTACHED FORMS

- 6.1 Outbreak form No.1
- 6.2 Outbreak form No.2
- 6.3 Outbreak form No.3
- 6.4 Outbreak form No.4

7. REFERENCES

- 7.2 General Directorate of Infection Prevention and Control (MOH)
- 7.3 GCC Manual for Infection Control 3rd Edition Manual(2018)



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8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



APPENDIX IPC-36-01

Modified CDC/Spaulding Classification of Contaminated
Patient Care Items and Environmental Surfaces

Classification	Description	Dental Clinic / Laboratory Examples	Relative Risk of Disease	Surface Recycling Process
Patient Care Items				
Critical	Penetrates tissue; Contacts open tissue	Cutting instruments; Surgical burs, files, and needles; handpieces and scaler tips	High	Heat sterilization; sterile, single –use disposables
Semi-critical	Contacts mucosa	Hand instruments (non- cutting; mouth props, plastic prophy angles; rubber dam frames	Intermediate	Heat sterilization; single use disposables; chemical sterilization
Non – critical (no intraoral contact)	Contacts unbroken skin	Blood pressure cuffs; radiograph head cone; pulse oximeters	Low	Clean with detergents (no blood or saliva); intermediate- level disinfection if visibly contaminated with blood; disposable barriers
Environmental Surfaces				
Clinical contact	Usually contacts dental personnel, but not patients	Dental unit surfaces; laboratory equipment	Very Low	Clean with detergent (no blood or saliva) and low-level disinfection (HIV/HBV label claim) Intermediate- level disinfection if visibly contaminated with blood; disposable barriers
Housekeeping	Rarely contacts dental personnel or patients	Floors; walls; countertops	Minimal	If no obvious blood, sanitize with detergent; intermediate-level disinfection if visibly contaminated with blood



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INTERDEPARTMENTAL POLICY AND PROCEDURE

IPP

VERSION:2

POLICY NUMBER:	IPP: IPC-037	APPLIES TO: PT CARE AREAS
TITLE:	MULTIDRUG RESISTANT ORGANISMS (MDRO) MANAGEMENT	
APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1. PURPOSE

- 1.1. This policy outlines the required steps needed to prevent the transmission of multidrug resistant microorganisms (MDROs) within the hospital.

2. DEFINITIONS

- 2.1. **MDRO: MULTIDRUG RESISTANT ORGANISMS**

3. POLICY

- 3.1. MDROs are bacteria that are resistant to many or all antibiotics.
3.2. Methicillin-resistant Staphylococcus aureus (MRSA) and vancomycin-resistant enterococci (VRE) are the primary resistant microorganisms encountered in the hospital.
3.3. The emergence of other gram-positive and gram-negative drug-resistant microorganisms is on the rise.
3.4. standard precautions must be observed for all patient care.

4. RESPONSIBILITY

- 4.1. IPC Team to Establish Surveillance
4.2. Patient Care Providers to Follow Isolation Precaution

5. PROCEDURES

5.1. Notification of the MDRO

- 5.1.1. The microbiology lab or Infection Control Practitioner (ICP) will notify the ward of the MDRO.
5.1.2. Patients previously or discharged MDRO positive are flagged in MDRO documentation.

5.2. Management of MDRO-positive patients

- 5.2.1. Initiate contact precautions in addition to standard precautions.
5.2.2. Patient must be in a single room or can be cohorted with another patient with the same organism.
5.2.3. MDRO-positive patients who are in multi-bed rooms can be managed temporarily while waiting to be transferred to a single room or an appropriate cohort.
5.2.3.1. Place a sign on the cubicle or curtain of the patient's bed
5.2.3.2. Ensure easy access to PPE and alcohol-based hand rub.
5.2.3.3. Practice strict standard precautions between interactions with patients in the room.
5.2.3.4. Transfer to a single room or cohort with another patient with the same organism as soon as possible.



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- 5.2.4. Place a contact isolation sign on the outside of the isolation room door.
- 5.2.5. Practice strict hand hygiene.
- 5.2.6. Cohort non-critical items such as stethoscopes and pressure cuffs with the patient.
- 5.2.7. Store the minimum amount of supplies in the patient's room.
- 5.2.8. Use an isolation cart for extra supplies (kept outside the room).
- 5.2.9. Ensure that all staff understand and comply with the isolation precautions and hand hygiene protocol.
- 5.2.10. Limit the patient's activity outside the room to treatments or tests.
- 5.2.11. Notify receiving departments/wards (e.g., Radiology, Endoscopy, Clinics, OR) of the patient's isolation status when the patient must be transported for treatment/tests.
(Refer to policy IPC-21 Transporting Patients on Isolation Precautions).
- 5.2.12. Ensure concurrent and terminal cleaning of the isolation room and equipment as per housekeeping procedure.
- 5.2.13. Handle/discard contaminated items as per Standard Precautions.
- 5.3. **Medical**
 - 5.3.1. Request Infectious Diseases consultation as needed by call 937.
 - 5.3.2. Discharge the patient from the hospital once his/her medical condition allows.
- 5.4. **Clearance/Discontinuation of Isolation**
 - 5.4.1. Discontinue isolation of MDRO-positive patient after consultation with the infection prevention control department.
- 5.5. **Screening of healthcare workers (HCWs) and the environment**
 - 5.5.1. Do not screen HCWs or the environment because it is not typically indicated and incurs unnecessary costs.
 - 5.5.2. IP&C may initiate such measures when indicated.
- 5.6. **Outbreak Management**
 - 5.6.1. Management of outbreaks will be coordinated by the ICP and will require the cooperation of medical, nursing, laboratory and other departments.
- 5.7. **Cleaning of the patient's room**
 - 5.7.1. Perform regular or terminal cleaning as per housekeeping protocol.
- 5.8. **Linen**
 - 5.8.1. Keep a linen hamper in the isolation area.
- 5.9. **MDRO bundle**
 - 5.9.1. To use appendix form IPC-37-01 MDRO bundle.
 - 5.9.2. Calculate MDRO bundle compliance rate.
6. **ATTACHMENT**
 - 6.1 appendix form MDRO bundle.
7. **REFERENCES**



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7.1. GCC Infection Prevention & Control Manual 3rd Edition, January 2018.

8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



MDRO BUNDLE FORM

SECTION - 1 PATIENT & HOSPITAL INFORMATION

Date
DD MM YY YY

MRN :

Location:

Surveillance
Plan Date : M M Y Y

ICU ☐ SCA ☐ Other :

Gender :

Male ☐ Female ☐

SECTION - 11 BUNDLE VARIABLES

Date	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	Remarks
1 Strict .Hand hygiene	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
2. Follow Standard Precautions	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
3. Use of Contact Isolation Precautions	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
4.Enhanced Environmental Cleaning	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
5.Continuous monitoring of MDRO thru screening	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
6.Optimize antibiotic use	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
7. Might add decolonization	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Signature									

Bundle Goal : Preventing MDRO by implementing (7) well – documented components of care.
If the case is **MRSA** please complete all documentation on MRSA Form and submit to Infection Control.

Outbreak : is defined as an unusual or unexpected increase of cases of a known HAI or the emergence of cases of a new infection.

Case Definition : must meet one of the following criteria:

- ✓ If the number of cases of HAIs exceed the facility own endemic rates.
- ✓ If there is more than 2 cases of HAIs with the same organisms linked to the same exposure at any given time or location within 3 days
- ✓ If there is more than 2 transferred patients to ICUs with the same HAIs at any given time
- ✓ If laboratory data shows 2 or more cases of : (MDRO) isolates that are resistant to more than 2 classes of antibiotics

FORM - 1 (IPC - 035)

Decolonization Record (Continuation)

Name of Patient: _____ Age: _____ Sex: _____ MRN : _____
Department & Room Number: _____ Diagnosis : _____

No. of Day	Date	Treatment Time	Chlorhexedine 4% Wash and Shampoo	Mupirocin / Bactroban Ointment	Name of Nurse
Day 1		AM			
		PM			
Day 2		AM			
		PM			
Day 3		AM			
		PM			
Day 4		AM			
		PM			
Day 5		AM			
		PM			
Day 6		AM			
		PM			
Day 7		AM			
		PM			

SCREENING 1 (Day 11)
SCREENING 2 (Day 14)
SCREENING 3 (Day 17)

DATE DUE: _____
DATE DUE: _____
DATE DUE: _____

DONE: _____
DONE : _____
DONE: _____

COMMENTS: _____


FORM - 1 (IPC - 035)

MRSA Decolonization Procedure

Name of Patient: _____ Age: _____ Sex: _____ MRN : _____
Department & Room Number : _____ Diagnosis : _____

Assessment for decolonization will be performed by the ICP in consultation with the attending physician and an Infectious Disease Consultant.

Maintain Contact Isolation During Decolonization Treatment:

 **SUPPLIES:** Chlorhexidine gluconate (CGH) 4 %
Mupirocin/Bactroban, per MD order
Clean Linens for the Bed and patient
Personal protective Equipment

PROCEDURES:

1. Spread full – strength CHG solution from neck to toes, ensuring coverage of underarms, groin, and between fingers and toes.
 - 1.1 Rinse with warm water and dry your skin from neck to toes with a clean towel
 - 1.2 Change the bed linens and the patient's clothing completely after each bath/shower
 - 1.3 Repeat this process twice a day
 - 1.4 Shampoo hair with the chlorhexidine solution for 3 days.
2. Apply Mupirocin/Bactroban ointment to anterior nares (inside nose) after chlorhexidine Treatment, when the patient is dry and dressed as ordered by the physician.

NB: Mupirocin should not be applied to open wounds.
3. These treatments must be given for 7 consecutive days.
4. Take a complete set of cultures from nares and previously positive sites 72 hrs. after decolonization.
 - 4.1 If first set of samples is negative repeat cultures 48 hours later.
5. Three negative cultures are required before the patient is cleared of MRSA and can be taken out of isolation.

NB: These results will be assessed by the ICP

NOTES:

1. The patient must not be on antibiotics at the time of screening
- 2.If any swabs is positive, stop the screening process until further assessment
3. Please complete all documentation on this form



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INTERDEPARTMENTAL POLICY AND PROCEDURE			
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	TITLE:	Surveillance Of Healthcare Associated Infection	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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1. PURPOSE :

- 1.1. This policy describes the steps needed to prevent the spread of MRSA to patients, staff and visitor.

2. DEFINITION:

- 2.1. MRSA refers to the strain of Staphylococcus aureus that is resistant to β – lactam antibiotics.

3. POLICY :

- 3.1. Concerns about MRSA are related to the potential for healthcare associated infection transmission and the limited number of antibiotics available to treat infections caused by this microorganism.
- 3.2. Screening can be initiated in emergency department (ER) .
- 3.3. Patients admitted from the Emergency Room who qualify for screening should not be held in the ER awaiting the screening results since this will unnecessarily delay admission.
- 3.4. Initiate empiric contact isolation precautions during screening procedure.
- 3.5. Standard precautions must be observed for all.

4. RESPONSIBILITY:

- 4.1. All care givers working to provide care to pt with MRSA
- 4.2. IPC teams to establish surveillance as MRSA protocols

5. PROCEDURES:

5.1. Management of suspected MRSA colonized patient :

5.1.1. Screen all patients who are :

- 5.1.1.1. Transfer from other hospitals or patients treated in another hospital, clinic within the past six months.

- 5.1.1.2. Known to be previously MRSA positive.

- 5.1.1.3. Roommates of positive patients not on precautions .

5.1.2. Sites to screen are :

- 5.1.2.1. Anterior nares.

- 5.1.2.2. Open skin areas (e.g. tracheostomy, pressure sores or surgical wounds).

5.1.3. Specimen collection :

- 5.1.3.1. Use sterile swab stick with transport medium.



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- 5.1.3.2. Clean the site with normal saline to remove debris before swabbing.
- 5.1.3.3. Moisten swab in transport medium before swabbing the site.
- 5.1.3.4. Use same swab for identical sites : one swab for both nares, one swab for both axilla and one swab for both inguinal areas.
- 5.1.3.5. Use separate swabs to screen other sites. **NB: The accompanying requisition should request "MRSA screen"**

5.1.4. Patient placement upon admission:

- 5.1.4.1. Request single room for Contact Isolation from Nursing Supervisor. If a single room not available then two or more MRSA patients for screening maybe **cohorted**, after consultation with Infection Control Staff.
- 5.1.4.2. Observe Contact Isolation precautions in addition to Standard Precautions.
- 5.1.4.2.1. Place contact isolation sign on the outside of isolation room door.
- 5.1.4.2.2. Ensure that all staff understand and comply with the isolation precautions and hand hygiene policy.
- 5.1.4.2.3. Cohort non – critical items such as stethoscope and pressure cuffs with the patient.
- 5.1.4.2.4. Store minimum amount of (daily) supplies in patient room.
- 5.1.4.3. Limit the patient activities outside of the ward.
- 5.1.4.4. Notify receiving departments / ward (e. g. Radiology, Clinics, OR) of patient's isolation status when patient must be transported for treatment / test. (Refer to policy IPC21: Transporting Patient on Isolation Precautions).
- 5.1.4.5. If patient is MRSA positive, refer to Management of MRSA positive patients below.

5.2. Management of Patients Confirmed Positive MRSA

- 5.2.1. Patients determined to be MRSA positive from surveillance screening upon or after admission.
- 5.2.2. Readmitted patients that were MRSA positive on discharge (flag / alert)
- 5.2.3. Microbiology Laboratory:
- 5.2.3.1. Notify the ward of MRSA- positive patients.
- 5.2.3.2. Notify the IPCD of all new positive MRSA cultures.
- 5.2.4. Nursing:
- 5.2.4.1. Request a single room from Nursing Supervisor. If a single room is not readily available, two or more MRSA – positive patients can be cohorted after consultation with IPCD staff.



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- 5.2.4.2. MRSA – positive patients who are in multi-bed rooms can be managed temporarily While waiting to be transferred to a single room or an appropriate cohort.
- 5.2.4.2.1. Place a sign on the cubicle or curtains of the patient's bed.
- 5.2.4.2.2. Ensure easy access to PPE and ABHR
- 5.2.4.2.3. Practice strict standard precautions between interactions with patients in the room.
- 5.2.4.2.4. Transfer to a single room or cohort with another patient with the same organisms as soon as possible.
- 5.2.4.3. Observe contact isolation precautions in addition to standard precautions with all Patient care activities.
- 5.2.4.3.1. Place a Contact isolation sign on the outside of the isolation room door.
- 5.2.4.3.2. Ensure that staff understand and comply with the isolation precautions and Hand hygiene protocol.
- 5.2.4.3.3. Cohort non – critical items such as stethoscopes and pressure cuffs along With the patient.
- 5.2.4.3.4. Store the minimum amount of supplies in the patient's room.
- 5.2.4.3.5. Use an isolation cart for extra supplies (kept outside the room).
- 5.2.4.4. Rescreening of MRSA – positive patients must occur in consultation with the IPCs.
- 5.2.4.5. Screen exposed patients who are shared a room with a known MRSA – positive for More than 48 hours.
- 5.2.4.6. Limit the patient's activities outside of the ward.
- 5.2.4.7. Notify receiving departments/wards of the patient's isolation status when the patient Must be transported for treatment / tests.
- 5.2.4.8. Maintain Contact isolation during decolonization process.
- 5.2.4.9. Ensure concurrent and terminal cleaning of the isolation room and equipment as per Housekeeping procedure.
- 5.2.4.10. Handle/discard contaminated items as per standard precautions
- 5.2.4.11. Cohorting nursing staff providing direct patient care is recommended.
- 5.2.5. Medical
- 5.2.5.1. Restrict antibiotic use (especially broad spectrum antibiotics) and invasive devices when possible.
- 5.2.5.2. Discharge the patient when his/her medical condition allows.



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5.2.5.3. Seek the advice of Infectious Disease Consultants of ICP regarding possible decolonization by call 937.

5.3. Discontinuation of Contact Isolation:

5.3.1. Discontinue isolation of a MRSA positive patient in consultation with ICP.

5.3.2. Criteria for discontinuing isolation :

5.3.2.1. Antibiotic therapy is completed at least three days prior to rescreening.

5.3.2.2. Vancomycin levels should be ZERO prior to rescreening.

5.3.2.3. Three consecutive negative cultures from all previously positive site. If the first set of sample which was taken 3 days off antibiotics is Negative, repeat cultures 48 hours later.

5.3.2.4. Patient should not be receiving antibiotic therapy at any time during the screening process.

5.4. Rescreening MRSA – positive Patients for the Purpose of Discontinuing Contact Isolation

5.4.1. Sites to screen:

5.4.1.1. Anterior nares

5.4.1.2. Previously positive sites

5.4.1.3. Any indwelling catheter sites

5.4.1.4. Non intact skin areas (e.g.; tracheostomy, pressure sores or surgical wounds)

5.5. Screening of HCWs and the Environment

5.5.1. Do not screen HCWs or the environment because it is not normally indicated and incurs unnecessary costs.

5.5.2. IPCD may initiate such measures when indicated.

5.6. Outbreak Management

5.6.1. Management of outbreaks will be coordinated by the IPCD and will require the cooperation of medical. Nursing, laboratory and other departments.

5.7. Cleaning of the Patient's Room

5.7.1. Regular cleaning as per housekeeping protocol

5.7.2. Terminal cleaning upon patient discharge.

5.7.3. The room can used as soon as all cleaned surfaces are dry.

5.8. Linen

5.8.1. Keep a linen hamper in the isolation area.

5.9. Ambulation

5.9.1. Patients with infected body fluids:

5.9.1.1. If they are able to contain their body fluids (secretions, urine, stool),



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patients may walk in the corridors but cannot enter the visitor/patient area.

5.9.1.2. If unable to contain their body fluids, patients must be encouraged to stay in their rooms and be reassessed frequently.

5.10. Watchers/Visitors

5.10.1. Provide information about MRSA as required.

5.10.2. Hand hygiene must be emphasized after patient contact.

5.10.3. Watchers and visitors must be instructed to wear appropriate PPE if assisting with direct patient care.

5.11. Decolonization Protocol (Refer to appendix IPC38-01MRSA Decolonization Procedure)

5.11.1. Treat nares topically for periods not exceeding seven days with Bactroban (Mupirocin) cream (only if the organism is Mupirocin – sensitive); restrict use as resistance to this agent is well documented.

5.11.2. IPC staff will assess patients on an individual basis to determine the need for Decolonization with chlorhexidine wash (suppressive therapy) to reduce/inhibit MRSA skin colonization.

6. REFERENCE:

6.1. GCC Infection Prevention & Control Manual 3rd Edition, January 2018

7. ATTACHMENT

7.1. MRSA Decolonization Procedure form



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8. APPROVAL'S:

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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	TITLE:	IPC IN DENTAL CLINIC	
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1. PURPOSE

1.1 To provide guidelines on proper infection control practices in dental care settings.

2. DEFENITION

N/A

3. RESPONSIBILITY

3.1. DENTAL CLINIC STAFF

4. POLICY

4.1 Patients and Dental healthcare workers may be exposed to a variety of infectious, viral, and bacterial agents in dental care settings.

4.2 Routes of microbial transmission:

4.2.1 General Routes:

4.2.1.1 Direct contact with a lesion, organisms or potentially infectious secretions when performing intraoral procedures (e.g., practicing without wearing gloves).

4.2.1.2 Indirect contact via contaminated instruments or disposable items (e.g., accidental percutaneous exposure from used needles).

4.2.1.3 Airborne or droplet via aerosolization of microorganisms from patients' blood or saliva while using devices that can generate droplet spatter (e.g., air water devices, dental hand pieces).

4.2.2 Dental healthcare workers and patients as modes of transmission during patients care:

4.2.2.1 Patient to Dental healthcare workers transmission of potentially infectious microbes can occur through breaks in the skin or through airborne exposure.

4.2.2.2 Dental healthcare workers to patient transmission of potentially infectious microbes can occur as a result of Dental healthcare workers bleeding into a patient's mouth after sharps exposure or through respiratory droplets passed from Dental healthcare workers to the patient.

4.2.2.3 Patient to patient transmission can occur if instruments are improperly reprocessed or due to improper hand hygiene or improper glove wearing on the part of Dental healthcare workers.

5. PROCEDURES

5.1 Treat every patient and instrument as potentially infectious with a life-threatening blood borne pathogen.



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5.2 Dental healthcare workers

5.2.1 All susceptible Dental healthcare workers should be vaccinated against hepatitis B. This vaccine is provided free of charge to at-risk employees by employ health clinic.

5.2.2 Response to hepatitis B vaccination (Anti-HBs) should be done after four weeks from completing vaccine series. (Refer to policy IPC-28 hepatitis B immunization for healthcare workers).

5.2.3 Must be provided with basic infection control license annually

5.3 Standard precautions

5.3.1 Practice standard precautions (hand hygiene and use of mask, gloves, goggles, face shield, gowns or aprons).

5.3.2 Dispose of sharps properly in puncture-proof containers; do not bend.

5.3.3 Use paper with impervious backing, aluminum foil, or plastic covers to protect items and surfaces (e.g., light handles or X-ray unit heads) that may become contaminated by blood or saliva during use and that are impossible to clean and disinfect. Remove these covers (while still gloved), discard them, and replace them (after ungloving and washing hands) with clean materials between patients.

5.4 Pre-procedural mouth rinsing

5.4.1 Patient should rinse with an antimicrobial mouth rinse before a dental procedure to reduce oral flora.

5.5 Unit dose concept

5.5.1 Preparing or dispensing a sufficient amount of material for a particular procedure before patient contact and discard any excess at completion. Single dose solutions or medications are recommended to prevent cross-contamination.

5.6 Patient screening and evaluation

5.6.1 Always obtain and determine the current health status of the patient, and always perform a thorough head, neck and oral examination to identify previously undiagnosed medical problems (examination may indicate a need for medical referral for the patient. e.g. for diagnosis of active tuberculosis).

5.7 Barrier techniques

5.7.1 The use of barriers is important for reducing tissue contact with potentially infectious pathogens and materials, ultimately reducing cross-contamination and cross-infection between Dental healthcare workers and patients.

5.7.2 Dental healthcare workers must wear protective attire when performing treatment procedures capable of causing splashes, spatter, contact with body fluids, or contact with mucous membranes or when touching items or surfaces that maybe contaminated with these fluids.



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5.7.3 The type of protection depends on the dental procedure.

5.8 **Instrument Reprocessing: Cleaning, Disinfection and Sterilization**

5.8.1 General principles

- 4.1 All dental and medical instruments can be classified into three categories: critical, semi critical or non-critical, depending on the potential risk for infection associated with their intended use and how they are reprocessed. (Refer to Appendix IPC 36-01:Modified CDC/Spaulding Classification of Contaminated Patient Care Items and Environmental Surfaces.

5.8.2 Dental instruments

5.8.2.1 Wear heavy-duty (reusable utility) gloves when dealing with instruments.

5.8.2.2 Clean the instruments should be done in Central Sterile Supply Department (CSSD) for disinfection and sterilization.

5.8.2.3 Place the instruments into a container and use pre-klenz gel to prevent organic material from drying on their surfaces, thus making cleaning easier.

5.8.3 Dental units and environmental surfaces can be divided into

5.8.3.1 Clinical surfaces

- After treatment of each patient and at the completion of daily work activities, clean countertops and dental unit surfaces that may have become contaminated with patient material. Use paper towels, an appropriate cleaning agent, and water for cleaning.
- After cleaning an environmental surface contaminated with patient material, disinfect it with a chemical germicide registered as a "hospital disinfectant" and labeled such intermediate-level disinfectants include alcohol 70% and chlorine-containing compounds such as diluted household bleach (sodium hypochlorite). The manufacturer's recommended contact time (kill time) should be used.

5.8.3.2 Housekeeping surfaces

- Clean floors, walls, and other housekeeping surfaces a hospital-approved low-level disinfectant such as a quaternary ammonium compound.

5.9 **Use and care of hand pieces, anti-retraction valve, and other intraoral dental devices attached to air and water lines**

- 5.9.1 Heat-sterilize all high-speed dental hand pieces, low-speed hand piece components used intraorally, and reusable prophylaxis angles. Acceptable methods of sterilization include steam under pressure (autoclaving), dry heat, or heat/chemical vapor. It is NOT acceptable to reprocess high-speed dental hand pieces, low-speed hand piece components used intraorally, and reusable prophylaxis angles by wiping or soaking



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these instruments in liquid chemical germicides.

- 5.9.2 Follow the manufacturer's instructions for cleaning, lubrication, and sterilization of hand pieces and reusable prophylaxis angles to ensure effective sterilization and longevity of the instruments.
- 5.9.3 Install anti-retraction valve (one-way flow check valves) in dental unit water lines to prevent fluid aspiration and to reduce the risk of the transfer of potentially infectious material. Ensure routine maintenance of anti-retraction valve.
- 5.9.4 Run high-speed hand pieces to discharge water and air for a minimum of 20 to 30 seconds after use on each patient. If possible, use an enclosed container or high velocity evacuation during discharge procedures to minimize the spread of spray, spatter, and aerosols.
- 5.9.5 At the beginning of each clinic day, remove hand pieces and allow water lines to run and discharge water for several minutes to reduce overnight microbial accumulation.
- 5.9.6 Use sterile water or saline as a coolant/irrigator when surgical procedures involve cutting bone.
- 5.9.7 After treatment of each patient, clean and sterilize reusable intraoral instruments attached to, but removable from, the dental unit air or water lines (e.g., ultrasonic scaler tips and their component parts and air/water syringe tips) in the same manner as hand pieces. Follow the manufacturer's instructions for reprocessing.
- 5.9.8 Some dental instruments have components that are heat sensitive or are permanently attached to dental unit water lines. Other instruments (e.g., handles or dental unit attachments of saliva ejectors, high-speed air evacuators, and air/water syringes) that do not enter the patient's mouth can become contaminated with oral fluids during treatment procedures. Cover these instruments with impervious barriers that are changed after each use or, if possible, clean and then disinfect them with an EPA-registered "hospital disinfectant."
- 5.9.9 Flush all water lines to all instruments thoroughly after the treatment of each patient and at the beginning of each clinic day.
- 5.9.10 Advise patients not to close their lips tightly around the tip of the saliva ejector to filter oral fluids.
- 5.10 **Water quality**
 - 5.10.1 Use water that meets the EPA regulatory standards for drinking water (i.e., <200 CFU/mL of heterotrophic water bacteria) for routine dental treatment output water. Schedule water sampling must be done to monitor water quality.
- 5.11 **Single-use disposable instruments**
 - 5.11.1 Use single-use disposable instruments (e.g., prophylaxis angles, prophylaxis cups



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and brushes, tips for high- speed air evacuators, saliva ejectors, and air/water syringes) for one patient only and discard after use.

5.12 Disposal of infectious waste materials

5.12.1 Pour blood, suctioned fluids, or other liquid waste into a drain connected to a sanitary sewer system.

5.12.2 Place solid waste contaminated with blood or other body fluids in sealed, sturdy impervious yellow bags that are leak Proof.

5.13 Dental radiography asepsis

5.13.1 Wear gloves when taking radiographs and when handling contaminated film packets. Other PPE (e.g., mask, protective eyewear, protective clothing) is required when spatter or splashes of blood or other potentially infectious materials is anticipated.

6. ATTACHMENT

4.1 Appendix IPC 36-01:Modified CDC/Spaulding Classification of Contaminated Patient Care Items and Environmental Surfaces.

7. REFERENCES

5.1 GCC Infection Prevention & Control Manual 3rd Edition, January 2018



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8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Noshili	IPC coordinator		1-7-2021
Reviewed by:	Ms. Ali Noshili	IPC Director		3-7-2021
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Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		20-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021

TABLE 1: INFECTION DISEASE CATEGORY

Categories	Diseases	Precautions	Bagging	Viewing	Washing in the hospital
I	Pathogens not listed under category II.	Standard ¹ Precautions	Yes	Allowed	Upon family request*
II	Anthrax Plague Rabies Smallpox Yellow Fever Hepatitis B Hepatitis C HIV SARS Emerging Avian influenza viruses Viral Hemorrhagic Fever (VHF) Creutzfeldt-Jacob disease with necropsy Other infectious disease as advised by the Infection Prevention & Control Department	Standard ² Precautions	Yes	Not allowed	Required**
	***VHF	Droplet and Contact precautions with impermeable PPEs	Double bagging not less than 150 um thick	Not allowed	Avoid body washing as per Fatwa

¹ Hand hygiene, gloves, surgical mask, water resistant gown, boots/shoe cover.

² Hand hygiene, gloves, N95, water resistant gown, boots/shoe cover.

* Washing can be done outside of the hospital setting.

** No washing can be done outside of the hospital setting.

*** Certain VHF disease will be exempted from body washing under the guidance of IP&C Department. Minimum handling of dead bodies will be mandated.



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1. PURPOSE

- 1.2. To provide food services staff with infection control and environmental health guidelines and standards to prevent food borne diseases and food poisoning.

2. DEFINITION:

- 2.1 No uncertain terms to be defined.

3. POLICY:

- 3.1 It is the policy of the dietary services that all staff shall comply with the infection control guideline to protect themselves and the patients served.
- 3.2 **Provide written standards for:**
- 3.2.1 Safe preparation, handling and storage of food to minimize contamination by microorganisms and chemicals.
 - 3.2.2 Cleaning and sanitizing of trays, utensils, tableware and other surfaces.
 - 3.2.3 Employee health and work restrictions.
 - 3.2.4 Employee orientation, education, and training.
 - 3.2.5 Valid health certificates review by employ health clinic and infection control department.
- 3.3 Conducts educational programs for personnel concerning food preparation and storage and personal hygiene and their relevance to food borne infections. The educational sessions should include and not be limited to the following:
- 3.3.1 Hand hygiene.
 - 3.3.2 Bacterial growth and temperature.
 - 3.3.3 Food storage, preparation, transportation and display.
 - 3.3.4 Sanitation and disinfection.
 - 3.3.5 Personal hygiene.

4. RESPONSIBILITY

- 4.1. EHC staff
- 4.2. dietary services supervisor
- 4.3. IPC Team to monitoring compliance dietary services staff

5. PROCEDURES

5.1 General instruction:

- 5.1.1 Assures that food handlers are monitored appropriately for illnesses.



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- 5.1.2 Restricts unauthorized personnel from entering food preparation areas and food facilities in general.
- 5.1.3 Restricts visitor entry unless the visitor is wearing a over coat and hair cover.
- 5.1.4 Assures that food handlers carry out all cleaning procedures in a manner consistent with optimal food hygiene.

5.2 Food handlers

- 5.3.1 In addition to the hospital pre-employment screening requirements, food handlers complete a screening process involving the following:
 - 5.3.1.1 Clinical examination (evaluation of the chest and abdomen as well as possible skin diseases and other communicable diseases).
 - 5.3.1.2 Chest X-ray to rule out pulmonary tuberculosis.
 - 5.3.1.3 Stool analysis for ova and parasites.
 - 5.3.1.4 Stool tests and cultures for Salmonella, Shigella and Vibrio cholera routinely upon hiring ,every 6 month and after returning from vacation.
 - 5.3.1.5 Vaccination for meningococcal disease, with a booster every 5 years.
 - 5.3.1.6 Vaccination for typhoid fever, with a booster every 5 years.
- 5.3.2 Receive a valid medical examination certificate indicating that they are free from infectious diseases and fit to work as a food handler; this certificate must be review by the Infection Prevention & Control Department and will be valid for one year, renewable yearly after an assessment of the food handler.
- 5.3.3 Follow proper and frequent hand hygiene and personal hygiene practices
 - 5.3.5.1 Fingernails: Keep fingernails trimmed and filed; do not apply finger nail polish or artificial fingernails.
 - 5.3.5.2 Jewelry: Do not wear jewelry on the arms and hands while preparing food to allow for proper hand hygiene.
- 5.3.6 Wear and maintain proper clean attire during food handling (clean uniform, apron, hair and beard restraint, clean gloves when needed). Do not wear street clothes in food service areas.
- 5.3.7 Do not eat, drink or smoke while preparing or handling food.
- 5.3.8 Do not go to the washroom with masks or gloves on.
- 5.3.9 Do not leave the work area with mask or gloves on.

5.4 Purchasing and receiving

- 5.4.1 Purchase food from a reputable source and inspect upon delivery for the expiration date and signs of spoilage.
- 5.4.2 Reject damaged food or containers.
- 5.4.3 Select food products in commercially filled, unopened packages whenever possible.
- 5.4.4 The receiving personnel should check the following items
 - 5.4.4.1 Temperature strips of potentially hazardous foods.
 - 5.4.4.2 Inspection stamps and labels/tags of meat, eggs, milk, poultry, fish, juice, and



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pureed food.

5.4.4.3 All use-by and expiration dates.

5.4.4.4 Color, texture, odor and condition of products.

5.4.4.5 Temperature of frozen and refrigerated food, including milk. When the outside temperature reaches 90°F (32°C), all refrigerated perishable item need to be refrigerated within 1 hour.

5.4.4.6 Open and examine contents of tampered or damaged containers; if appropriate reject product.

5.4.4.7 Inspect for signs of pest infestations and/or spoilage.

5.4.5 Store perishable foods immediately at the proper temperature.

5.4.6 Dispose of damaged items.

5.5 Storage

5.5.1 Store non-perishable food in clean, dry, properly ventilated areas and inspect them periodically for expiration dates and any signs of spoilage.

5.5.2 Store food in designated areas. Do not store in housekeeping and dishwashing areas or near any sources of potential contamination.

5.5.3 Store in clean wrappers or containers with covers; label contents appropriately with date when item was received.

5.5.4 If products are removed from original container that has the lot number, it is important to maintain lot numbers to be able to track and recall in the event of an identified problem.

5.5.5 Store eggs in original container in the refrigerator at 45°F (7°C).

5.5.6 Remove all corrugated cardboard as soon as possible, because these boxes may deteriorate or damage the product, the product may leak, or water damage may be present, any moisture rots the boxes, and these conditions allow for pest infestation and possible damage to the product.

5.5.7 Keep storage areas and vehicles that transport food clean. The area must have variable lighting, ventilation, and air circulation. A temperature range for dry storage is 50°F to 70°F (10°C to 21°C). Document monitoring of temperature in a log book.

5.5.8 Low temperature storage maintenance:

5.5.8.1 Fruit and vegetables (except those in dry storage): 40°F to 45°F (4°C to 7°C).

5.5.8.2 Dairy products, meats, poultry, fish, and shellfish: 32°F to 40°F (0°C to 4°C).

5.5.8.3 Frozen foods: -10°F to 0°F (-23°C to -10°C).

5.5.9 Keep temperature logs of all storage areas, if a problem occurs, correct it and record the methods used to correct it, date, sign, and file.

5.5.10 Store food at least 6-inches above the floor level on clean racks with slatted shelves or racks that prevent cross-contamination and proper air circulation. Never cover the slats with foil or other materials as this prevents flow of air, and, keep away from walls to facilitate cleaning and allow for pest control measures.



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5.5.11 Shelving must allow for cleaning under the bottom of the shelf or flushing of the floor, away from walls to facilitate cleaning and reduce infestation of pests.

5.5.12 Storage shelves should be at least 2 inches from outside walls that may sweat because of differences between inside and outside temperatures.

5.5.13 Implement cleaning schedules and monitor for cleanliness, temperature, ventilation, and pest infestation.

5.5.14 Never store toxic materials used for cleaning and sanitation in food storage area. Label and store in a locked area away from food and paper goods.

5.5.15 Use the first in first out (FIFO) procedure to rotate stock. Periodically check the expiration dates on all food and supplies.

5.5.16 Monitor the temperature of all refrigerators and freezers and record them daily in a log.

5.5.17 Maintain good housekeeping and hygienic conditions.

5.5.18 Segregate food products according to each type such as poultry, meat, vegetables and fruits.

5.6 Preparation

5.6.1 Instruct personnel and supervise them regarding personal hygiene and food safety during food preparation.

5.6.2 Wash vegetables and fruits properly.

5.6.3 Thaw either in a microwave or refrigerator or under running water. Do not thaw at room temperature.

5.6.4 Do not thaw and refreeze.

5.6.5 Cook food thoroughly to reach the correct temperature for the specific type of food.

5.6.6 Store food protected at the proper temperature once prepared to avoid contamination. Do not allow food to sit uncovered at room temperature.

5.6.7 Avoid handling of food with bare hands; use proper, clean utensils such as tongs and spoons.

5.6.8 Use separate cutting boards for raw meat, poultry, fish, raw fruits and vegetables and cooked food unless boards are non-absorbent (and will not scratch, chip, or crack) and can be cleaned and sanitized adequately between uses.

5.6.9 Use clean equipment and utensils during food preparation and avoid cross contamination.

5.6.10 Food and service workers responsible in the preparation of food should wear disposable gloves. Gloves should be removed before leaving the work area. When returning to the work area, hand hygiene must be performed and new gloves should be worn. Gloves should be changed and hand hygiene performed whenever the gloves are contaminated by touching potentially soiled surfaces such as floors, waste cans, cardboard, boxes, etc.

5.7 Prevention Strategies for Safe Food Handling



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- 5.7.1 Label all food with the preparation date and time.
- 5.7.2 Thaw food
- 5.7.2.1 Under refrigeration in which food temperature is maintained at or below 41°F (5°C).
- 5.7.2.2 Completely submerged under potable running water (at a water temperature of 70°F (21°C)).
- 5.7.2.3 Place food in a water type bag and submerge in cold water (change the water every 30 minutes).
- 5.7.2.4 As part of the cooking process; or, in a microwave and immediately transferred to conventional cooking equipment with no interruption in the process.
- 5.7.3 No precooking and holding meats for final cooking.
- 5.7.4 Chill cooked perishable leftover foods to an internal temperature of 5°C (41°F) or less or to 7°C (45°F) or less within 2 to 4 hours of preparation.
- 5.7.5 Do not stack shallow pans on top of each other (allow air to circulate around food being chilled).
- 5.7.6 Rapid heating to 165°F (74°C) within 2 hours.
- 5.7.7 Keep hot food at 135°F (57°C) or higher.
- 5.7.8 Stirring food while holding.
- 5.7.9 Do not pour a batch of new hot food into a batch of hot food being served.
- 5.7.10 Do not use hot food-holding equipment (such as steam tables) to reheat food.
- 5.7.11 Do not reuse food or condiments that have been previously served to customers (butter, sauce, dressings, chips, or bread).
- 5.7.12 Use sanitized, calibrated thermometers to monitor the temperatures, as required.
- 5.7.13 All monitoring records should be documented in a log book.
- 5.8 Transport, display and serving**
- 5.8.1 Transport food to different areas while protected in temperature-controlled carts.
- 5.8.2 Establish safe times for food items to be stored in inpatient care areas.
- 5.8.3 Protect food on display from customer contamination by the use of easily cleanable counter protector devices.
- 5.8.4 Maintain food on display at the proper temperature, whether hot or cold.
- 5.9 Washing and cleaning**
- 5.9.1 Establish comprehensive cleaning schedules to include different areas, equipment, fixtures, and physical facility structures (e.g., walls, floors).
- 5.9.2 Monitor dishwasher washing and rinsing temperature to achieve proper sanitation and cleaning of food utensils.
- 5.9.3 After manual washing, sanitize all utensils and equipment either with hot water (70°C) or the use of sanitizer (sodium hypochlorite) with the appropriate concentration and exposure time.
- 5.9.4 Wash all working surfaces: thoroughly rinse and sanitize them after each use with the



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proper sanitizer, dilution, exposure time and water temperature.

5.10 Water

5.10.1 Use clean, potable and safe water in the food service facility. Test water routinely for its quality and potability.

5.11 Waste management

5.11.1 Store garbage in leak- and pest-proof containers with tight-fitting covers.

5.11.2 Store all garbage containers either outdoors or above a smooth surface of nonabsorbent material.

5.11.3 Wash containers and sanitize them routinely in an area provided with a floor drain connected to a sanitary sewer.

5.12 Pest control

5.12.1 To prevent the access of pests to food areas and allow for extermination, if necessary, follow appropriate pest control measures (e.g., sanitation, screens, closure of cracks and holes).

5.12.2 Contracting with a pest control company to visit the department at least once a month

5.13 Maintenance

5.13.1 Identify and follow a cleaning and sanitization procedure for each piece of equipment used in food services.

5.14 Work restrictions

5.14.1 Kitchen staff with respiratory infections, gastroenteritis, diarrhea or hand infections or wounds are restricted from handling food.

5.14.2 Refer the staff to employ health clinic or emergence department for treatment.

5.14.3 The employee must have a medical report from the employee health clinic to return to work.

6. ATTACHMENT

6.1.NIL

7. REFERENCES

7.1 GCC Infection Prevention and Control 3rd Edition Manual (2018)



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8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
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	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		20-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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DEPARTEMNTAL POLICY AND PROCEDURE			
DPP VERSION:2	POLICY NUMBER:	DPP: IPC-041/42	APPLIES TO: MORTUARY
	TITLE:	MORTUARY CARE	
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1. PURPOSE

- 1.1 To provide clear infection control standards and guidelines on the appropriate care of the body following death to protect healthcare workers (HCWs), morgue staff and families from potential infectious exposures.

2. DEFENITION

- 2.1. N/A

3. RESPONSIBILITY

- 3.1 MORTUARY STAFF
3.2 NURS INCHARGE
3.3 DUTY MANGER

4. POLICY

- 4.1 All dead bodies, body parts are considered potentially infectious and standard precaution is always observed at any time by any staff attending.
- 4.2 Guidelines and standard on proper care of the body must be followed to protect HCW and families from potential exposure risk.
- 4.3 Preparing the deceased for the morgue always involves the handling of blood, body fluids, and biological agents and may also involve exposure to life-threatening biologicals, chemicals, radiation, or electrical current.

5. PROCEDURES

5.1 Nurses

- 5.1.1 Adhere to standard precautions and use appropriate personal protective equipment (PPE) at all times.
- 5.1.2 After the physician declares death, perform the following tasks to prevent exposure to blood and body fluid during transportation to protecting morgue personnel:
- 5.1.2.1 Remove all disposable tubes and lines appropriately.
- 5.1.2.2 Dress all wounds with impervious material to prevent oozing of body fluids or bleeding from wounds or previous catheter sites.
- 5.1.2.3 Request an appropriately sized body bag and place the body in the bag.
- 5.1.3 Follow the proper identification of the body, transportation, and documentation in the morgue.
- 5.1.4 Identify Patients with known infectious diseases and they should have body tags labeled with the appropriate category.(see table No.1)
- 5.1.5 The nurse in charge or dedicated personnel will inform the morgue supervisor if the deceased was known to harbor an infectious agent. (This information will also be



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DEPARTEMENTAL POLICY AND PROCEDURE

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confirmed in writing on the identification tag attached to the body bag.)

- 5.1.6 Body parts (including placentas, stillborn, products of miscarriage, etc.) must be place in a red bag, clearly labeled, and stored in the refrigerator until delivery to the morgue.

5.2 Morgue Staff

- 5.2.1 Oriented and train all morgue staff and especially body washers through in-service training annually regarding the proper infection control practices (i.e., hand hygiene, modes of disease transmission, and the importance of PPE) and how to apply these practices.

- 5.2.2 Observe always standard precautions and use appropriate personal protective equipment (PPE) at all times.

5.2.2.1 Avoid direct contact with blood and body fluids.

5.2.2.2 Use PPE (mask, goggles, latex/vinyl gloves, boots, waterproof full-length apron) to prevent splashing and contamination with body fluids.

- Remove disposable PPE and discard immediately after the task is completed.
- Reusable aprons and boots must be cleaned between patients and at the end of each shift.

5.2.2.3 place contaminated linen in a laundry bag and send to the laundry.

5.2.2.4 Ensure that the body bags (which are plastic) are appropriately disposed of when the body is removed (in a yellow bag).

5.2.2.5 Do not drink or eat inside the morgue.

5.3 Needle stick or body fluid exposure

- 5.3.1 Evaluated all morgue staff in the Employee Health Clinic on a yearly basis for regular checkups and at any other time as deemed necessary (such as after an exposure to body fluid or blood

- 5.3.2 Ensure that the death log book is available in the morgue.

5.4 Morgue Facility and Maintenance

- 5.4.1 Keep the morgue clean at all time.

5.4.2 For long term preservation of dead bodies, must provide a deep freezing compartment (temp<-15°C). we have agreements with AAGH to transferring long term dead body

- 5.4.3 Monitor the temperature of the refrigerators (2-4°C) and record the temperature on the temperature chart on a daily basis.

5.4.3.1 Any temperature failure (temperature out of range) must be reported to the Utilities and Maintenance (U&M) Department.

- 5.4.4 Clean and disinfect all equipment, table and counter surfaces, and transport trolleys after



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every patient and at the end of the day.

5.4.4.1 All tabletops, stretchers, and body boards must be made of washable material (plastic, vinyl, or stainless steel) to avoid water and body fluid contamination.

5.4.4.2 Use hospital-approved disinfectants.

5.4.5 Store all flammable chemicals and materials appropriately to avoid accidental exposure.

6. ATTACHMENT

6.1 Table No. 1 (Infection Disease Category)

7. REFERENCES

7.1 GCC Infection Prevention and Control 3rd Edition Manual (2018)

8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Noshili	IPC coordinator		1-7-2021
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	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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DEPARTEMNTAL POLICY AND PROCEDURE			
DPP VERSION:2	POLICY NUMBER:	DPP: IPC-042	APPLIES TO: LAUNDRY
	TITLE:	LAUNDRY	
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1. PURPOSE

- 1.1 To describe infection control practices for the hospital laundry to protect workers from exposure to potentially infectious materials during the collection, handling and sorting of soiled linen, which may be contaminated with blood and body fluids or other infectious material. Also, to describe infection control standards for the laundering process to restore soiled linen to a usable condition.

2. DEFINITION

- 2.1 **CLEAN LINEN** –Linen that has gone through the proper laundry processing to be rendered safe to handle by staff and for patient use.
- 2.2 **DIRTY (Non Infectious) LINEN** – Are linen that has been used or has come into contact with a contaminated surface, i.e., floor, dirty linen, patients, equipment etc.
- 2.3 **INFECTIOUS LINEN** – Linen that are soiled with body fluids, blood or linen that are being used in the care of patient with diseases necessitating any for isolation precaution.

3. POLICY

- 3.1 To reduce the possibility of occupational risks of infection transmission and/or exposure, laundry workers should focus on:
- 3.1.1 Appropriate and frequent hand hygiene.(Refer to policy hand hygiene).
- 3.1.2 Appropriate use of personal protective equipment (PPE).
- 3.1.3 Removal of foreign objects from soiled linen.
- 3.2 To restore soiled linen to usable condition, washing, bleaching, rinsing, and drying are necessary.

4. RESPONSIBILITY:

- 4.1 Laundry Personnel- responsible to provide quality services to patients and staff by maintaining a proper procedure on clean laundry to prevent spread of infection through improper washing & handling.
- 4.2 Health inspectors – responsible to monitors the process of line management in laundry.

5. PROCEDURES

5.1 **Personal Protective Equipment (PPE) And Hand Hygiene**

- 5.1.1 All staff must be trained in the collection, transport, sorting and washing of soiled linen using the appropriate infection control measures, such as hand hygiene,



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- wearing PPE and adhering to standard precautions.
- 5.1.2 Staff must be educated in the use of PPE
- 5.1.2.1 When and what is needed.
- 5.1.2.2 How to put on correctly.
- 5.1.2.3 Where to dispose of used PPE.
- 5.1.3 PPE requirements differ depending on the assigned area of the laundry.
- 5.2 **Collecting Contaminated Textile/Linens**
- 5.2.1 Nursing : The nurse should wear appropriate PPE when handling used or contaminated line.
- 5.2.1.1 Contaminated linen should be bagged at the site of generation in a manner that minimizes agitation and prevents contamination of the environment and personnel.
- Do not shake contaminated linen when removing it from the bed.
 - Place used linen in a laundry bag at the point of use.
 - Do not place on chairs or other furniture.
- 5.2.1.2 Collect soiled linen in such a fashion as to keep the heavily soiled portion contained in the center by folding or rolling the soiled spot into the center. This action will reduce the risk of contamination and prevent leakage from soaking through.
- 5.2.1.3 Care should be taken before placing soiled linen in a laundry bag to ensure that all non-textile items, including instruments, needles, or plastic single-use under pads, are removed. These items can cause extensive damage to laundry equipment.
- Items of this nature present the greatest risk to the HCW of acquiring a blood-borne infection.
 - Ensure that the patient's personal items (e.g., dentures, eyeglasses, and hearing aids) are not left in the linen.
- 5.2.1.4 Laundry bags should not be filled more than $\frac{3}{4}$ full. Once full , tie off soiled linen bags in the dirty utility room or a designated area for pickup by laundry staff. Linen bags must not be placed on the floor; use a bin or rack to keep the bags 8 to 10 inches off of the floor.
- 5.2.1.5 Storage of soiled linens collected from the different areas of the hospital waiting for transport to the laundry service should be kept in an area that is not accessible to the public.
- 5.2.1.6 Linen from isolation rooms is considered regular soiled linen.
- 5.2.2 Laundry staff



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- 5.2.2.1 Observe Standard Precautions while moving, loading and unloading soiled linens.
- 5.2.2.2 Linen should not be sorted or pre-rinsed in patient care areas.
- 5.2.2.3 Care should be taken when removing laundry bags from these areas. Do not overfill the carts.
- 5.2.2.4 Do not hold bags close to the body, this step will help prevent the possibility of sharps injury from forgotten items in the linen.
- 5.2.2.5 If Standard Precautions are followed when handling these soiled linens, the bags do not need to be color-coded or labeled.
- 5.2.2.6 The laundry provider must maintain functional separation of clean from soiled linens in carts and/or vehicles at all times during the collection and transportation of soiled linens.

5.3 Sorting Soiled Linen

- 5.3.1 All personnel involved in the sorting and washing of contaminated healthcare linen should:
 - 5.3.1.1 Be appropriately trained.
 - 5.3.1.2 Have adequate access to hand hygiene facilities.
 - 5.3.1.3 Use PPE (overalls, mask, head cover, heavy duty gloves, and boots).
- 5.3.2 The bagged linen should be delivered to the 'soiled' area of the laundry.
- 5.3.3 It is important to be alert for sharp objects while sorting linen. If found, sharps must be disposed of appropriately.

5.4 Laundering process (washing, rinsing, drying)

- 5.4.1 The laundering process is designed to remove organic soil and render the linen clean. The correct amount of each chemical (at an adequate dilution), the mechanical action of the equipment, the water flow, the water temperature, the timing (cycles), and drying must be optimized as part of the process
 - 5.4.1.1 **High temperature:** A temperature of at least 71°C (160°F) for a minimum of 25 minutes is normally recommended for the hot water wash cycle.
 - 5.4.1.2 **Low temperature:** A lower temperature of 22°C-25°C (71°F-77°F) can satisfactorily reduce microbial contamination in the washer.
 - The washing cycles (one for bleach wash), series of rinses, and the last rinse will neutralize any residual chemicals.
 - The amount of residual chlorine (bleach) should be between 50 and 150 ppm and must be monitored and controlled.

5.5 Packaging and Storing



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- 5.5.1 Maintain the lines in a clean state for delivery to the department.
- 5.5.2 Wrapped liners into fluid-resistant bundles or place bundled but unwrapped linens into fluid-resistant covered carts or hampers.
- 5.5.3 Keep unwrapped linens into carts or hampers covered at all times. If the cart does not have a solid bottom, it must be lined with heavy plastic or impervious paper before placing clean linens inside.
- 5.5.4 Store bundled and wrapped linens in open racks in the laundry provided the integrity of the bundled and wrapped linens is not compromised.
- 5.5.5 You may store unwrapped clean linens in designated rooms, where only the appropriate personnel have access to it. Keep the door close at all times.
- 5.5.6 Reprocess any lines that become soiled during the packaging and storage.

5.6 Delivery of Clean Linens

- 5.6.1 Maintain functional separation of clean from soiled linens during transportation by bagging soiled linens in fluid-resistant containers.
- 5.6.2 Do not store clean and soiled linens in the same container.
- 5.6.3 Clean and disinfect properly carts, container, covers, and liners used to collect or transport soiled linens after the cart is emptied and before any next use.
- 5.6.4 Clean the interior of the transport carts or containers on a regular basis or when visibly soiled.

5.7 Needle/Sharps Injuries

- 5.7.1 Instruct laundry employees to report any sharps injury occurring when handling linen as well as any improperly disposed sharps or needles.
- 5.7.2 Provide a sharps container in the soiled linen area to dispose of any sharps found in the linen.

5.8 Physical Facility

- 5.8.1 Separation of clean and soiled linen
 - 5.8.1.1 Separate the areas for sorting and processing soiled linens from the areas for ironing folding, and storing clean linen.
 - 5.8.1.2 Separate the abovementioned areas with physical barriers and ensure appropriate ventilation.
- 5.8.2 Hand hygiene facilities: The laundry areas must have hand hygiene facilities soap, water, paper towels, or alcohol hand rub) and PPE available for workers.

6. ATTACHMENT

- 6.1 N/A



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7. REFERENCES

7.1 GCC Infection Prevention and Control 3rd Edition Manual (2018)

8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Noshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Noshili	IPC Director		3-7-2021
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	Mr. Ahmed Najmi	Laundry supervisor		9-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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1. PURPOSE

- 1.1 To establish infection control guidelines for the healthcare workers in the Labor and Delivery area.

2. DEFINITION

- 2.1 **Restricted area:** The restricted areas include the labor and delivery room.
2.2 **Semi-restricted area:** The semi-restricted areas include the hallway outside D.R.

3. POLICY

- 3.1 N/A

4. RESPONSIBILITY

- 4.1 All employees, contract workers, Volunteers, and students healthcare workers in the Labor and Delivery area. This includes physicians, anesthesiologists, nurses and all ancillary personnel.

5. PROCEDURES

5.1 Labor and Delivery Personnel

- 5.1.1 Personnel shall comply with the pre-employment and the annual employee health requirements.
- 5.1.2 Employees shall eat and drink only in designated areas.
- 5.1.3 A cap that covers all hair including beard and side burns, mask and eye protective shields, sterile gloves and sterile gowns shall be worn by all personnel involved in deliveries that take place in the restricted area.
- 5.1.4 Standard Precautions shall be followed for all patients.
- 5.1.5 Sharps shall be disposed of in puncture-resistant leak proof containers. The containers shall be closed and replaced when $\frac{3}{4}$ full.
- 5.1.6 Hand washing:
- 5.1.6.1 A surgical scrub (or alcohol gel) is required prior to each delivery or surgical procedure (Refer to policy Hand hygiene)
- 5.1.6.2 Circulating nurses and observers need not scrub but shall wash their hands between cases.
- 5.1.6.3 Good hand washing is also essential before and after routine patient contact (as in the labor and recovery rooms).



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5.2 Patients

5.2.1 Pre-operative and operative surgical preps shall be conducted as ordered by the operating surgeon and as outlined in the Nursing Procedure Manual.

5.2.2 Isolation will be initiated when appropriate (see policy Isolation.)

5.3 Family Members

5.3.1 Family members will be asked to don appropriate PEE prior to entering the Labor and Delivery department.

5.3.2 Caps that cover all hair on the head and face are required.

5.4 Non-OR Personnel : Personnel who are not permanently assigned to the OR, but who must enter the Labor and Delivery

5.4.1 Must follow the dress code as discussed by the Labor and Delivery .

5.4.2 Must use appropriate PPE.

5.4.3 Caps that cover all hair on the head and face are required.

5.5 Antimicrobial Prophylaxis

5.5.1 Cesarean Sections

5.5.1.1 Laboring patient – If a patient has already received antibiotics for any of a number of reasons, it will be at the discretion of the surgeon whether to administer any at the time of cesarean section. This decision may be based on the duration of time since an antibiotic was administered, the indication for antibiotic use, the pharmacokinetics of the medications used, the clinical condition of the patient, and the circumstances occurring at the time of the surgery.

5.5.1.2 It will be at the discretion of the surgeon whether to administer antibiotics for scheduled repeat or elective cesarean sections. The literature is not conclusive on this issue.

5.5.2 Antibiotic Choice

5.5.2.1 The choice of the antibiotic will be left to the surgeon. The antibiotic generally used is a cephalosporin, but circumstances may necessitate use of a different antibiotic in some cases.

5.5.3 Timing and Administration

5.5.3.1 The antibiotic will be given intravenously by the anesthesiologist immediately after the umbilical cord is clamped.



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5.5.4 Documentation

- 5.5.4.1 The decision not to administer prophylaxis should be made by the obstetrician; a physician's order to withhold antibiotics should be placed in the patient's chart in this Case.
- 5.5.4.2 If prophylaxis is ordered, the anesthesiologist will administer it and document this on the anesthesiology OR flow sheet.
- 5.5.4.3 The circulating nurse will also document whether prophylaxis was administered or not on the OR nurse records. When prophylaxis is not given, the nurse will document the reason it was not given in the OR nurse records.

5.6 OR Suite Set-up

- 5.6.1 Vaginal delivery packs will be opened and instrument tables set up for no longer hours. A label with date and time will be placed on the table when set up. After this time, the tables will be cleared, instruments will be reprocessed and other items discarded or reprocessed.
- 5.6.2 Cesarean section trays and packs will be opened and tables set up for no longer than 8 hours. A label with date and time will be placed on the table when set up. After this time, the tables will be cleared, instruments will be reprocessed and other items discarded or reprocessed.
- 5.6.3 Anesthesiology staff will not set up the fluid warmer "Hot Line" in advance of cases.
- 5.6.4 The intravenous set up for peripheral IV's will be assembled and placed in the warmer for no longer than 24 hours. The assembly will be labeled with date and time when set up. The IV set up will be placed in a yellow bag to prevent inadvertent touch contamination. After 24 hours, the tubing and fluids must be discarded.

5.7 Monitoring Post Cesarean Section Surgical Site Infections

- 5.7.1 The appearance of the surgical site in patients with suspected infection should be documented in the patient's medical record.
 - 5.7.1.1 Drainage (purulent, serous, serosanguinous)



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5.7.1.2 Erythema

5.7.1.3 Swelling

5.7.1.4 Tenderness

5.7.2 Specimens of drainage or a swab of tissues in a newly opened surgical site should be sent for culture.

5.7.3 When surgical site infection is diagnosed, the diagnosis should be documented in the patient's medical record and the causative microorganism recorded when established by culture.

5.8 Environment

5.8.1 Traffic in and out of the OR delivery rooms shall be kept to a minimum to prevent air turbulence created by activity. Surgical caps must be worn in all semi-restricted and restricted areas.

5.8.2 Doors shall be kept closed in the OR delivery rooms. Movement and conversation during cases shall be minimized.

5.8.3 The back door leading from the delivery suite shall not be used as a short cut to transport supplies to or from any area.

5.8.4 All organic matter on the floor shall be immediately wiped up by a gloved hand and an absorbent cloth. This cloth shall be immediately discarded in the linen hamper. The gloves shall be removed before any further handling of supplies for the case. Spills shall be cleaned up appropriately.

5.8.5 Sponge buckets shall have waterproof liners.

5.8.6 All waste that is saturated or dripping with blood or other bloody body fluids shall be discarded in a yellow bag as biohazardous waste.

5.8.7 Birthing Room Environment:

5.8.7.1 Items in the room (furniture, drapes, pictures, etc.) shall be made of durable materials with a smooth impervious surface which can be cleaned and disinfected easily.

5.8.7.2 Routine terminal cleaning of the room(s) shall be performed after the room has been vacated.

5.8.8 Housekeeping

5.8.8.1 Termination of Case

- Linens: The linen shall be bagged and taken to the soiled linen area.



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- Kick Buckets: Kick bucket bags and sponge bags shall be securely closed before disposal. If the contents are saturated with blood or bloody body fluids, these bags shall be placed in a yellow biohazard bag before discarding.

5.8.8.2 Equipment

- All reusable items shall be sterilized or properly disinfected prior to reuse.
- All disposable items shall be discarded after use.
- Floors shall be wet mopped after each case.
- Operating tables shall be thoroughly cleaned after each case.

5.8.8.3 All blood spills or spills of bloody body fluids shall be cleaned according to the hospital guidelines. (Refer to spill kit management)

5.8.8.4 Daily Cleaning

- Floors shall be thoroughly cleaned.
- All horizontal surfaces and furniture (i.e., operating tables, instrument tables, and cabinet doors) shall be cleaned and disinfected.
- Kick buckets shall be cleaned, disinfected and relined.
- Wheels and castors shall be cleaned and inspected carefully for debris.
- Sinks and faucets shall be cleaned with a suitable abrasive.
- Lounges, offices and workrooms shall be cleaned daily and kept in good order.
- Cleaning equipment shall be taken apart, cleaned with a detergent germicide, and allowed to dry.
- Routine cleaning schedules shall be established for the warmers, refrigerators, cabinets, storage areas, and other permanent equipment. Cleaning of these items/areas shall be documented.
- Floors are scrubbed on a weekly basis and whenever soiled with blood or other body fluids.
- All blood shall be handled as if it were infectious. Bulk blood and bloody body fluids shall be carefully poured into the sewage system for disposal.



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5.8.9 Specimens

5.8.9.1 Culture specimens shall be sent immediately to the laboratory in appropriate sterile specimen containers. The outside of the container shall be clean and labeled appropriately.

5.8.9.2 Specimens going to Pathology shall be cautiously handled as infectious material.

- Frozen specimens are to be put in a 4x4 moistened with saline and then placed into a sterile specimen container. Pathology shall pick up these specimens after they have been called.
- All other specimens shall be placed in a clean container with a sealed lid. Formalin fixative is used for other specimens, placentas, and fetuses.
- Large specimens shall be placed in a sealed container and then placed in a plastic bag.
- The containers for all pathology specimens shall have attached to the outside a clean label for identification and the outside shall be free of any spoilage
- All specimens that cannot be sent immediately to pathology shall be placed in the appropriate refrigerator. No food, medicine or blood shall be placed in the same refrigerator.

5.8.10 Disinfection and Sterilization

5.8.10.1 Disinfection and sterilization shall be carried out according to the hospital guidelines.

5.8.10.2 Items to be sterilized are sent to Sterile Processing.

5.8.10.3 All sterilized items shall be labeled with the name of the item. The policy for event related sterility shall be followed.

5.8.11 Storage of Clean and Sterile Supplies

5.8.11.1 All clean/sterile supplies shall be stored on shelves and be dust free.

5.8.11.2 All sterile supplies inside each sterile pack shall be checked routinely for expiration dates.

5.8.12 Medications

5.8.12.1 Multi dose vials of medication shall be discarded according to the Pharmacy policy.

5.8.12.2 Single dose vials shall be supplied whenever possible.



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5.8.12.3 Irrigation fluids such as saline and water shall be discarded 24 hours after opening.

6. REFERENCES

6.1 GCC Infection Prevention and Control 3rd Edition Manual (2018)

7. ATTACHMENT

7.1 N/A

8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
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	Mr. Fahd Najmi	Nursing director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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DEPARTEMENTAL POLICY AND PROCEDURE			
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	TITLE:	IPC IN INTENSIVES CARE UNIT	
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1. PURPOSE:

- 1.1 To provide guidelines to reduce healthcare associated infection (HAI) in ICU
- 1.2 To prevent the transmission of infection to personnel, patients and visitors in the unit.

2. DEFINITION:

2.1 A hospital facility for provision of intensive nursing and medical care of critically ill patients, characterized by high quality of continuous nursing and medical supervision and by use of sophisticated monitoring and resuscitative equipment and maybe organized for the care of specific patient.

3. RESPONSIBILITY:

- 3.1 All personnel in ICU

4. POLICY:

- 4.1 It is important that personnel working and attending to patient including non – ICU staff visiting the unit understand the activities which may influence the risk of hospital acquired infection within the unit. This will facilitate taking appropriate infection control measures to prevent or reduce ICU risk to staff and patients.
- 4.2 Factors which predispose patients in ICU to risk of infection:
 - 4.2.1 Length of stay.
 - 4.2.2 Patients often have underlying conditions that compromise their host defenses (e.g.; extreme of age, nutritional status, abnormal immune response, etc.)



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4.2.3 They are exposed to invasive procedures and some of which may be done in emergencies

wherein traditional infection control practices and standards can not always be implemented

4.2.4 They are often near highly susceptible, infected or colonized patients with the opportunity for cross infection since contact between patient and staff are frequent.

4.2.5 They often undergo high rate of antibiotic usage that predisposes them to resistant microorganisms.

5.0. PROCEDURE:

5.1 Hand Hygiene

5.1.1 Operation within the unit should encourage infection control practices like handwashing

or the use of alcohol based hand rub.

5.1.2 Hand washing or the use of alcohol based hand rub (ABHR) shall be performed before entering the unit and after leaving the patient care area.

5.1.3 Before performing any invasive procedure

5.1.4 Before preparing medication and preparing IV fluids

5.1.5 After touching contaminated environmental surfaces

5.1.6 Whenever hands are dirty

5.1.7 Hand washing between patients

5.2 The Use of Personal Protective Equipment

5.2.1 Gloves should be worn for any high risk patient's contact

5.2.2 Gloves should be changed between contacts

5.2.3 Sterile gloves must be worn when performing aseptic procedures in the unit and non – sterile gloves for procedures like emptying urinary bags and contact with contaminated items.

5.2.4 Wash hands AFTER removing the gloves



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5.2.5 Use non – sterile gloves when handling respiratory secretions or discharges from patients like stool or urine

5.2.6 .Use gown to protect the patient from contact with the wearers clothing and prevent contamination.

5.2.7 Long sleeved gown are worn by staff to protect uncovered skin during procedures and activity which may result in skin exposure to blood, body fluids, secretions and excretions or items contaminated with those substances.

5.3 Decontaminating Equipments

5.3.1 Equipments such as ventilators, suction machines should be cleaned and disinfected between patients

5.3.2 Equipments with direct contact with patients skin or mucous membrane should be decontaminated with high level disinfectant or sterilized between patient.

5. 3.3 Examining equipments such as stethoscope and ophthalmoscopes should be decontaminated with alcohol wipes or other disinfectant between patients.

5.4 Isolation Facilities

5.4.1 Isolation precautions should be implemented for infected or suspected patients admitted to or diagnosed within the unit.

5.4.2 Inform other departments regarding patient's diagnosis with known or suspected communicable disease if procedures are necessary to prevent exposure of other personnel.

5. 4.3 Communicate with infection control supervisor/practitioner about any patient with known or suspected infectious disease.

5.4.4 Notify Infection Control Supervisor/Infection Control Practitioner of all healthcare associated infection (HAI) which occurs in patients or detection of any unusual clustering of the same organisms among patient in the unit. Institute appropriate isolation precaution immediately to avoid unnecessary transmission of the disease to non-infected patient or personnel.

5.5 Environmental Control



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- 5.5.1 The traffic flow should be controlled to reduce sources of contamination from visitors, staff visiting non – ICU staff and equipments.
- 5.5.2 Sufficient space should be provided around each patient for personnel and equipment to reduce chance of direct transmission of pathogens through contact.
- 5.5.3 The beds are 2.5 – 3 meters apart to allow free movement of staff and equipments.
- 5.5.4 Sharps containers, waste bin and infectious waste bin are accessible near the bed.
- 5.5.5 Provide privacy for patients in the unit by installing curtains between patients bed.
- 5.5.6 Clean storage room should be separated from the waste storage area.
- 5.5.7 Sinks and hand rub dispensers must be available and accessible inside the patient care area
- 5.5.8 Waste storage designated for ICU must be closed all the time.

5.6 Visitors

- 5.6.1 The number of visitors should be restricted. One visitor at a time for not more than 5 minutes.
- 5.6.2 Children and visitors with communicable diseases are not allowed to enter the ICU
- 5.6.3 Visitors will be asked to wash hands or hand rub and be given mask, gown before coming to patient's bedside.

5.6.4 Refer to IPP IPCM – 026 Patient Visiting Hours and Regulations

5.7 Non – ICU Personnel

- 5.7.1 Street coats and white coats must be covered with disposable gown.
- 5.7.2 Hand washing and ABHR before and after entering the patient care area
- 5.7.3 Mask are worn inside the patient care area

5.8 Environmental Cleaning

- 5.8.1 ICU must be kept clean. Floors and horizontal surfaces should be cleaned daily with routine hospital approved disinfectant to remove dirt.
- 5.8.2 Walls, curtains should be cleaned to avoid accumulation of dust
- 5.8.3 Minimize risk of equipment contamination



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5.8.4 Schedule should be established for routine cleaning of all patient care equipment

5.8.5 Equipment like ventilator must be replaced, cleaned and disinfected between patients on regular basis.

5.8.6 Upon patient's discharge, bed of infected cases is swabbed and send to laboratory and thorough cleaning of bed, bedside tables and equipment begin and completed before new patient is admitted.

5.8.7 General cleaning will depend upon the availability of the unit. At least weekly general cleaning of all areas including bathrooms and storage area is recommended.

5.9 ICU Personnel

5.9.1 All ICU staff must have orientation in Infection Control before starting to work in the unit.

The topics taken during the orientation are hand hygiene, proper disposal of waste, needle prick injury, environmental hygiene and guidelines in laundry, proper use of PPE, disinfecting medical equipments and use of PPE.

5.9.2 All staff should have Hepatitis B and develop antibody after immunization.

5.9.3 All staff shall have screening (e.g.; TB)and other immunizations (e.g.;Meningitis, Influenza) in Employee Health Clinic (EHC)

5.10 Reprocessing Method

5.10.1 Equipment and Patient Care Articles

5.10.1.1 Ventilatory circuits

5.10.1.1.1 Disposable tubing does not routinely need to be changed for single patient unless it becomes visibly contaminated, malfunction or within 3 – 4 days

5. 10.1.1.2 Multiple used tubing must be heat disinfected or sterilized according to manufacturer's manual. The use of non – disinfected tubing between patient increases the risk of chest infection due to gram negative bacilli (e.g.; Pseudomonas Aeruginosa)

5.10 .1.1.3 If properly maintained, a ventilated patient may use the same circuit for 3 – 4 days before reprocessing becomes necessary.



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5.10.1.1.4 Use heat moisture exchanger to prevent pneumonia in patient receiving a mechanically assisted ventilation. Change the heat moisture exchanger when it malfunction mechanically or become visibly soiled.

5.10.1.1.5 Change heat moisture exchanger every 48 hours. Install filters on the expiratory and inspiratory ends of the ventilator to prevent contamination

5.10.1.2 Endotracheal Suction Catheters

5.10.1.2.1 Closed suction catheters that incorporate a protective sleeved do not to be changed every 24 hours

5.10.1.2.2 Disposable suction catheters are used for respiratory tract suctioning. This device shall be discarded after each use or may be use for maximum of 6 hours on the same patient.

5.10.1.2.3 The water used for flashing the catheters after suctioning must be sterile and hands to be disinfected after.

5.10.1.2.4 Suction catheters must not be shared between patients.

5.10.1.3 Endotracheal Tubes

5.10.1.3.1 Use disposable endotracheal tubes

5.10.1.3.2 Recycled endotracheal tube maybe used after thorough cleaning and autoclaving if disposable endotracheal tube is not available.

5.10.1.4 Ambu Bag

5.10.1.4.1 Ambu bags are difficult to disinfect. The bag must be rinsed thoroughly in sterile water after immersion in chemical disinfectant. This will reduce the risk of chemical irritation which can precipitate respiratory infection.

5.10.1.4.2 Oxygen Delivery Mask

5.10.1.4.2.1 This can be reusable or disposable

5.10.1.4.2.2 Wash thoroughly and soak in chlorine (500ppm) rinse, dry and store.

5.10.1.5 Suction and Drainage Bottles



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5.10.1.5.1 These are disposable with self sealing container held in a clear plastic container.

5.10.1.5.2 Ensure that the outer container is disinfected after emptying.

5.10.1.5.3 For non – disposable bottles, it must be changed at least every shift (8 – 12 hours) or sooner if full. The contents maybe emptied down the assigned sink or toilet.

5.10.1.5.4 It must be rinsed and autoclaved

5.10.1.5.5 If sterilizing facilities are not available, wash thoroughly, dry and perform high level disinfection.

5.10.1.6.6 Recycled connector tubing must be cleaned and sterilized, if, disposable not available.

5.10.1.6.7 Do not leave fluids standing in the suction machine bottle.

6.0. ATTACHMENT

6.1 N/A

7.0. REFERENCES:

7.1 APIC Text of Infection Control & Epidemiology, 2016



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8.0. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd Najmi	Nursing director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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1.0. PURPOSE:

- 1.1 To establish guidelines to prevent cross infection within the area.
- 1.2 To prevent surgical site infection in the operating room
- 1.3 To describe the precautionary measures needed for staff to follow when dealing with isolated patients who will undergo surgical procedures in the operating room.

2.0. COMMENTS:

- 2.1 Operating Room personnel and housekeeping staff will work together to provide a safe, clean environment for the surgical patient and personnel. Standard precautions will be followed by all personnel.
- 2.2 Communication and screening systems should be in place so that OR personnel are aware of or informed about infectious status of the patient before arriving in the operating room.

3.0. DEFINITIONS:

- 3.1 **Standard Precautions** are precautions used for all patients regardless of their infectious status to prevent transmission of blood borne diseases
- 3.2 **Surgical Asepsis** is the absence of microorganisms in the surgical environment to reduce the risk of infection.
- 3.3 **Unrestricted Zone** area in OR which interfaces with other department that includes holding area, reception, and others.
- 3.4 **Restricted Zone** area in OR wherein sterile scrub attire, masks are required includes the operating room and sterile core area.
- 3.5 **Semi-restricted Zone** area in OR where scrub suit is required and areas where surgical instruments are processed.

4.0. PROCEDURES:

4.1 ROOM PREPARATION:

4.1.1 Room Preparation Before First Case and Between Cases:

- 4.1.1.1 All horizontal surfaces including OR table and surgical lights will be damp dusted with a towel moistened with an approved disinfectant.
- 4.1.1.2 Floors will be mopped with hospital approved disinfectant
- 4.1.1.3 Line all kick buckets and trash cans with appropriate plastic liners
- 4.1.1.4 Place linen bags in appropriate holder.

4.1.2 Cleaning During the Case:

- 4.1.2.1 Areas contaminated by organic debris (such as blood) during the procedure should receive immediate attention by applying an appropriate agent.



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- 4.1.2.2 Sponges should be discarded into plastic lined containers, counted and contained in an impervious receptacle.
- 4.1.2.3 Personnel should use gloves, instruments or both in counting and containing sponges.
- 4.1.2.4 Unnecessary traffic in and out of the room should be **discouraged** to minimize human bacterial shedding and curtail air turbulence.
- 4.1.2.5 The exterior surfaces of soiled specimen containers should be cleaned prior to removal from the operating room. Requisitions that are visibly soiled should be changed & discarded
- 4.1.2.6 Instruments should be **sprayed with Pre-Klenz** immediately **after case** to assure no transporting of microorganisms and to maximize the functioning of instruments.

4.1.3 Cleaning After Case

- 4.1.3.1 All items that have come in contact with the patient and / or sterile field should be considered contaminated, and their disposition and should reflect appropriate contamination control measures.
- 4.1.3.2 Gowns and gloves should be removed (inside out) and placed in proper receptacles prior to leaving the operating theatre.
- 4.1.3.3 Reusable woven fabrics, whether soiled or not, should be placed in laundry bags, which are then securely closed
- 4.1.3.4 Wet drapes should be placed in a plastic bag in an effort to prevent soaking through to the cloth hamper bag.
- 4.1.3.5 Non – woven fabrics, soiled sponges and other waste articles should be discarded into impervious bags for proper disposal
- 4.1.3.6 Sharps should be handled and disposed of according to hospital policy
- 4.1.3.7 Instruments, basins, trays and other items should be handled only by a gloved person until terminally sterilized and disinfected.
- 4.1.3.8 Wall suction units should be disconnected by circulating personnel to avoid contamination of wall outlets.
- 4.1.3.9 Disposable suction tubing should be used because of difficulties encountered in cleaning the lumen of reusable suction tubing.
- 4.1.3.10 Glass suction containers should be rinsed and terminally sterilized.
- 4.1.3.11 Disposable suction containers should be discarded after use.
- 4.1.3.11 Disposable anesthesia circuits, masks and endotracheal tubes should be discarded after use in appropriate containers.
- 4.1.3.12 The horizontal surfaces of furniture, overhead lamps and equipment lamps



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and equipment used in the surgical procedure should be cleaned with an appropriate agent

4.1.3.13 Spot cleaning should be done as necessary

4.1.3.14 A clean mop head and solution should be used to mop the floor.

4.1.4 Terminal Cleaning

4.1.4.1 At the completion of the day's scheduled , each OR and scrub/utility area, and corridors should be cleaned.

4.1.4.2 Furniture and equipment should be thoroughly scrubbed with an appropriate agent and good mechanical friction;

4.1.4.2.1 Wheels and casters should be cleaned and kept free of debris

4.1.4.2.2 Spotlight should be cleaned

4.1.4.2.3 All wall-mounted or ceiling mounted equipment should be cleaned

4.1.4.3 Doors of cabinets and operating rooms, especially around handles and push plates should be cleaned.

4.1.4.4 Scrub sink areas should be cleaned daily or more frequently if warranted

4.1.4.4.1 Disposable scrub brushes will be restocked as needed. Alcohol based, hand rub agents will also be stocked as needed.

4.1.4.4.2 Disposable brushes or nail cleaners should be discarded after use.

4.1.4.4.3 No dirty instrumentation should be cleaned in the scrub sink

4.1.4.5 Floors should be totally flooded and the solution picked up via the wet vacuum system. If a wet vacuum system is unavailable, a clean mop head and solution should be used in each room.

4.1.5 Cleaning Hallways:

4.1.5.1 Floors should be kept free of debris and mopped with hospital approved disinfectant daily.

4.1.5.2 Any liquid spills such as soap and water will be mopped up promptly

4.1.5.3 Sinks will be cleaned daily with hospital approved disinfectant.

4.1.6 Cleaning Workrooms and Storage Area:

4.1.6.1 Sinks, counters and other work surfaces will be cleaned daily with hospital approved disinfectant.

4.1.6.2 Shelves and drawers will be cleaned weekly with hospital approved disinfectant.

4.1.7 Cleaning Dressing Rooms and Lounges:

4.1.7.1. Areas will be vacuumed or mopped daily



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4.1.7.2 Worn scrub attire will be placed in the hamper bags provided. These containers will be collected as necessary by Laundry staff and or by Housekeeping staff for disposable scrub suits.

Cleaning Equipment:

4.1.7.2.1 All janitorial closets will be cleaned on a daily basis by Housekeeping Staff

4.1.7.2.2 Cleaning clothes and mop heads will go to the Laundry daily

4.1.7.2.3 Equipment used in cleaning will be taken apart daily.

4.1.7.2.4 Trash and line disposal areas will be cleaned daily.

4.1.8 Cleaning Other Equipment;

All other equipment such as x-ray machines, video towers, microscopes, fracture table, nitrous tanks or other specialty equipment will be cleaned as necessary using manufacturer's cleaning recommendation. It is the responsibility of the Operating Room staff to see that this equipment is properly cleaned before and after operative procedure.

4.2 PRINCIPLES OF ASEPTIC PRACTICES IN OR:

4.2.1 All materials in contact with surgical wounds must be sterile. Sterile items in contact with unsterile items is rendered contaminated.

4.2.2 Gown of surgical team are considered sterile in front from chest to the level of the sterile field. The sleeves are considered sterile two inches above the elbow to the stockinet cuff.

4.2.3 Sterile drapes are used to create a sterile field. Only the top surface of the drape table is considered sterile.

4.2.4 Items are dispensed to a sterile field by methods that preserves the sterility of the item and the integrity of the sterile field. After the sterile package is opened, the edges are considered unsterile. Sterile items including solution is delivered to a sterile field or handed to a scrubbed person in a way that sterility of the item is not compromised.

4.2.5 The movement of the surgical team is from sterile to sterile areas and from unsterile to unsterile areas. Scrubbed person and sterile items contact only sterile areas. Movement around the sterile field must not cause contamination of the sterile field. At least 1 foot distance from the sterile field must be maintained to prevent inadvertent contamination.

4.2.6 Whenever a sterile area is breached, the area should be considered contaminated. A tear or puncture of a drape permitting access to an unsterile surface underneath render the area unsterile.

4.2.7 Sterile field are prepared as close as possible to the time use.



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4.3 ENVIRONMENTAL CONTROL IN OR

Surgical asepsis requires meticulous cleaning and maintenance of the OR environment. Floors And horizontal surfaces are cleaned meticulously and frequently with detergent and soap or detergent germicide. Airborne bacteria are one concern. And to decrease the amount of bacteria, standard OR ventilation require 15 – 20 air exchanges per hour and positive pressure in the area is maintained. System with high efficiency particulate air (HEPA) filters are needed to remove particles larger than 0.3 micron μm . Unnecessary movement of personnel maybe restricted to minimize bacteria in the air and achieve negative or less than 3% OR infection rate. Temperature should be maintained between 18 - 24°C. The OR shall be 1°C cooler than the outside.

- 4.3.1 Outer zone (Unrestricted area) main door, accessible area for removal of waste, storage of medical supplies, an entrance to changing facility and sluice.
- 4.3.2 Semi-restricted zone- the sterile supplies store, anesthetic room, recovery room, scrub up area, clean control corridor, nurses station.
- 4.3.3 Restricted zone – the cleanest area which includes the OR theater and sterile preparation area for surgical instruments and equipments. The staff working in this area must wear sterile gown, mask, gloves and cap. Only those involved in actual operation will be present in the area. These should unidirectional access from this area to the operating room.

4.4 PATIENT PREPARATION FOR SURGERY:

4.4.1 Patient preparation

4.4.1.1 Require patient to take shower or bath with an antiseptic soap, night before operative day.

4.4.1.2 Do not remove hair pre-operatively unless hair around the incision site will interfere with the operation. Shaving is prohibited in OR.

4.4.1.3 Wash and clean around the incision site to remove contamination before performing antiseptic preparation of the skin.

4.4.2 Pre – operative antimicrobial prophylaxis

4.4.2.1 Use antibiotics for procedures in which use has shown to reduce surgical site infection.

4.4.2.2 Use antibiotic that are safe and bactericidal with a spectrum that covers intra-operative contaminants.

4.4.2.3 Maintain therapeutic level of the antimicrobial agent in both serum and tissues throughout the operation and until few hours after the surgery.

4.4.2.4 Do not prolong prophylaxis throughout the post – operative period. There is no evidence that prolong use of antibiotics has any advantage but instead creates antibiotic resistant microorganisms.



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4.4.2.5 Giving antibiotics pre-operatively is not an alternative for good infection control practices and surgical technique.

4.4.3 Patient's skin preparation

4.4.3.1 1% iodine in 70% and 0.5% chlorhexedine in 70% alcohol are the two most Effective skin antiseptics.

4.4.3.2 Alcohol solutions are preferred to aqueous solutions for skin preparation but it is important to allow the alcohol to dry after application and before the use of electro cautery.

4.5. STANDARD PRECAUTION IN OPERATING ROOM:

4.5.1 Hand hygiene by OR personnel is the most effective method of infection control for Prevention of infection inside operating room.

4.5.2 Surgical hand washing – All personnel in OR must perform surgical hand washing before any surgical procedure. (Refer to Hand Hygiene Policy)

4.5.3 Use of protective clothing for OR personnel to protect patients from microorganisms that may be transmitted from surgical team and to protect the surgical team from exposure to blood pathogens.

4.5.3.1 Mask should be worn to cover mouth and nose. It must be changed when wet, and in between cases. The mask should not be hanging around the neck or put inside pockets for reused. High efficacy mask should be available for surgical procedures especially patients with suspected or confirmed active disease of Mycobacterium tuberculosis.

4.5.3.2 Gown is to protect patients from skin of personnel and protect clothing from blood body fluids. Sterile gown should be worn in OR suite.

4.5.3.3 Sterile drapes are used to create barrier between the surgical field and potential Sources of bacteria.

4.5.3.4 Scrub suits are clothes worn by surgical team which they use inside OR over which sterile gown and apron is worn. It should be changed when they become soiled.

4.5.3.4 Surgical cap is use to confine hair to reduce contamination of the surgical field through shedding from scalp and hair.

4.5.3.5 Eye protection & face shield is to be worn to protect the eyes, nose and mouth of surgical team from splashes of blood or other body fluids.

4.5.3.6 Closed footwear are recommended to prevent transfer of organisms from shoe to OR vicinity and to give comfort to surgeons for long hours of standing while doing surgical procedure.



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4.5.3. Sterile surgical gloves that is well fitted to surgical personnel doing a surgical procedure is used in OR to minimize transmission of microorganisms from hands of the personnel to patient and prevent contamination of the sterile field. Gloves is changed if contaminated or if integrity is compromised.

4.6 MANGEMENT OF PATIENT IN ISOLATION PRECAUTIONS IN THE OR:

This is to describe the precautionary measures needed for staff to follow when dealing with Isolated patients who will undergo surgical procedures in the operating room. Communication and screening systems should be in place so that OR personnel are aware of or Informed about the infectious status of the patient before arriving in the OR.

4.6.1 Precautions for managing patients on Airborne Precautions in the OR

- 4.6.1.1 In patients with active MBT, only emergency procedures are recommended.
- 4.6.1.2 Elective procedures on patients who have MTB should be postponed until the patient is no longer infectious.
- 4.6.1.3 If possible, perform procedures in operating rooms that have anterooms. For operating rooms without anterooms, the doors to the operating rooms should be closed, and traffic into and out of the room should be made to perform the procedure at a time when other patients are not present in the operative suite and when the minimum number of personnel are present (e.g.; at the end of the day)
- 4.6.1.4 OR personnel should wear the N95 masks throughout the procedure.
- 4.6.1.5 Let the patient recover in the operating room, if a negative pressure room is not available, or alternatively, in a private room with a portable HEPA filter.
- 4.6.1.6 Follow cleaning and disinfection process of the room and equipment .
- 4.6.1.7 Follow Transporting Patients on Isolation Precautions

4.6.2 Precautions for managing patients on Droplet Precautions.

- 4.6.2.1 Elective procedures on patients who are under droplet precaution preferably to be delayed until no longer infectious or schedule the procedure at the end of the day.
- 4.6.2.2 Initiate and maintain droplet precautions when there is suspected or confirmed diagnosis of an infectious diseases that is transmitted by the droplet route.
- 4.6.2.3 Wear a surgical mask within 3 feet of the patient. (Refer to Transmission – based Isolation Precautions Policy).
- 4.6.2.4 Clean and disinfect the operating room and equipment used after the surgical procedure based on Housekeeping Policy.
- 4.6.2.5 Utilize the operating room for the next procedure after the recommended housekeeping cleaning process has been completed.
- 4.6.2.6 Refer to Transporting Patients on Isolation Precautions.



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4.6.3 Precautions for managing patients on Contact precautions

4.6.3.1 Schedule elective procedure preferably at the end of the day.

4.6.3.2 Place patient in isolation in a single room in the recovery.

(Refer to Transmission –based Isolation Precautions Policy)

4.6.3.3 Clean and disinfect the OR and equipment used after the surgical procedure based to Housekeeping Policy.

4.6.3.4 Refer to Transporting Patients on Isolation Precautions.

5.0. RESPONSIBILITY

5.1. OR STAFF

6.0. ATTACHMENT

6.1. N/A

7.0. REFERENCES:

7.1. GCC Infection Prevention and Control Manual, 3rd Edition, January 2018



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8.0. APPROVAL

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DEPARTEMENTAL POLICY AND PROCEDURE			
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1. PURPOSE

- 1.1 To Whilst planning the resumption of elective surgical cases, facilities need to prioritize and ensure that stringent infection control policies and procedures are being implemented. These policies need to be monitored and reported through clinical governance systems. Incident reporting structures need to enable a rapid response mechanism to ensure adherence and compliance. These recommendations should be read with the SCDC elective surgical services guidelines

2. DEFINITION

- 2.1 N/A

3. RESPONSIBILITIES

- 3.1 SURGICAL AND OR STAFF

4. POLICY

- 4.1 N/A

5. PROCEDURE

- 5.1 preoperative evaluation :

5.1.1 If patients are fit for surgery, the evaluation for risk and symptoms related to COVID-19 will be conducted with confirmatory tests if symptoms are prevalent

5.1.2 The surgery should be deferred for any patients attended with fever or respiratory symptoms and further evaluation can be conducted for COVID-19

5.1.3 These Infection control precautions and recommendation are focus on patients, staff, facility and surgery :

5.1.3.1 For Patients :

- Patient must be evaluated for covid-19 before surgery using Preoperative COVID-19 checklists for elective surgery form twice:
 - first time during the preoperative evaluation (at 24-72 hours before the surgery).
 - Second time in the day of surgery (or day



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prior, surgeon's discretion).

- On the day of surgery, patient will fill again the covid-19 questionnaire during the preoperative evaluation. if no concern, patient will go for surgery, otherwise he will be directed to the related specialty for further workup
- No accompanying family member should be permitted. If the patient has limited mobility or disabilities requiring help then one family member/care giver can be permitted. This should be confirmed prior to the admission date.
- Must wear surgical mask on the day of surgery
- Must reassess for symptoms of COVID-19

5.1.3.2 For Staff :

- Adherence to WHO five moments and COVID-19 specific recommendation for hand hygiene
- Staff should keep social distancing (minimum 1.5 m distance when possible) and use personal protective equipment (gloves, gown, surgical mask, and goggles).
- Intubation should be performed with only the necessary staff in the operating room, and staff must wear N95 masks(fitted) and eye protection.
- Delays between room re-entrance by necessary staff and between cases.
- Minimize staffing as much as possible.
- Follow the recommendation regarding the test after exposure according to the updated (Management of Healthcare Workers Exposed to COVID-19 guidelines).
- Staff should be trained in protecting themselves and patients

5.1.3.3 For Facilities:



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- Immediate cleaning and disinfection of contact surfaces after each procedure.
- Operating/procedural rooms must meet engineering and facility standards for air exchanges.
- Protocols or flow charts for managing and isolating patients and staff suspected of or confirmed to have COVID-19 infection

5.2 Before, During and After Surgery :

5.2.1 Pre-operative :

- 5.2.1.1 Patient must be evaluated for covid-19 before surgery using Preoperative COVID-19 (Mentioned above).
- 5.2.1.2 Surgical durations should be kept short.
- 5.2.1.3 Limited number of operations per operation room block.
- 5.2.1.4 Disinfect the operating room strictly between cases with the MOH approved disinfectant, and document cleaning between cases.
- 5.2.1.5 Health Care Workers who are under training or attending OR for training purpose such as interns or medical students are not recommended to attend the OR

5.2.2 During operation :

- 5.2.2.1 Health staff must wear N95 for all aerosol generating procedures (AGP's) even if the patients were asymptomatic and COVID-19 test were negative.
- 5.2.2.2 Minimize the amount of equipment, supplies and personnel in the room to the most needed.
- 5.2.2.3 When the patient is inside the operating room minimize traffic into and out of the room; only open the door, if necessary and the theatre door should be closed with warning sign outside the door to notify other OR staff with "no entry without permission".



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5.2.2.4 During intubating or extubating a patient allow only the in-charge anesthesiologist and two assistant nurses at max

5.2.3 Post-operative :

5.2.3.1 Allow the patient to recover in the Theatre Room.

5.2.3.2 Thoroughly clean and decontaminate all surfaces, screens, keyboard, cables, monitors, and anesthesia machine according to the manufacturer recommendation.

5.2.3.3 Attending OR staff should remove all PPE inside the theatre except the respirator or surgical mask removed outside then hand hygiene is essential.

5.2.3.4 Discard all unused items on the drug tray and airway trolley after each patient.

5.2.3.5 Apply terminal cleaning and disinfection of the operating theater according to the housekeeping policy of the hospital.

5.2.3.6 It is recommended to use a H2O2 fumigation machine or UV germicidal irradiation equipment in the last of day

6. ATTACHMENT

- 6.1 Elective Surgery during COVID-19 Pandemic flow chart
- 6.2 Patient Assessment For Elective Surgery form

7. REFERENCES

- 7.1 Infection Control Precautions and Recommendations for Elective Surgeries, 2020---



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8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
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	Ms.Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



Form 1: Preoperative COVID-19 checklists for Elective Surgery

Date: _____ Time: _____ MRN: _____
Name: _____ ID#: _____ Hospital: _____

Circle the number reflecting the patient's condition (exposure and clinical picture) and calculate the final score:

Risks for COVID-19		Score
A. Exposure Risks		
Close physical contact with suspected case* of COVID-19 in the past 14 days.		5
Close physical contact with a confirmed case* of COVID-19 in the past 14 days.		10
Working or visiting a healthcare facility.		5
B. Clinical Signs and Symptoms		
1. Fever or recent history of fever.		10
2. Cough (new or worsening).		10
3. Shortness of breath (new or worsening).		10
4. Nausea, vomiting, and/or diarrhea.		5
5. Positive lab result of COVID-19 within 2 weeks		10
6. Positive lab result of COVID-19 more than 2 weeks		5
Total Score		

* Patient or household

High risk	≥10
Low risk	<10

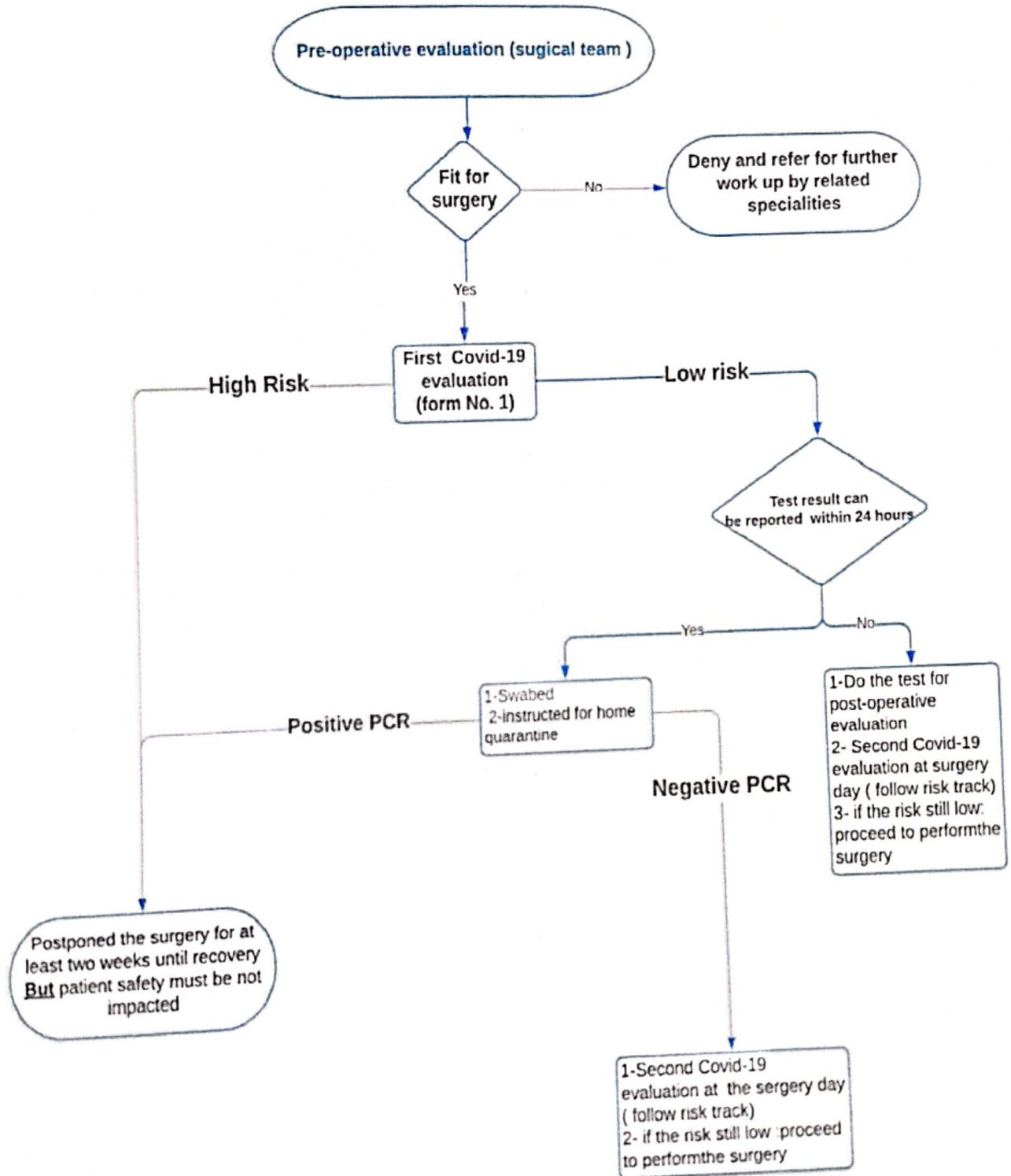
Staff name: _____ ID number: _____

Note:

The patient must be evaluated twice:

- With preoperative assessment.
- Day of surgery (or day prior, surgeon's discretion)

Elective surgery during Covid-19 Pandmic





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1. PURPOSE

1.1 To provide guidelines on proper infection control practices in PHARMACY DEPARTEMENT

2. DEFENITION

2.1 To provide clear guidelines for pharmaceutical staff on the correct procedures for preparation, storage and monitoring of sterile products kept in the pharmacy and to prevent the contamination of sterile products prepared within and outside the pharmacy

3. RESPONSIBILITY

3.1 Pharmacy staff

4. POLICY

4.1 pharmacist and pharmacy technicians are the professionals responsible for the preparation and storage of compound sterile and non-sterile products. Failure to follow sterile compounding standards and proper aseptic technique could lead to intrinsic and extrinsic contamination, which may result in microbial colonization or infection in the patient.

4.2 Patient morbidity and mortality can result from contaminated pharmaceutical items.

Sterile pharmaceutical products can become contaminated via two general methods:

4.2.1 Intrinsic contamination: occurs during the manufacturing process.

4.2.2 Extrinsic contamination: occurs subsequent to manufacturing; during the admixture process or while the infusate is used.

4.3 Compounding is the process of combining drug ingredients to prepare medications that are not commercially available or to alter commercially available medications to meet specific patient needs such as dye-free or liquid formulations.

4.4 Modes of contamination of sterile pharmaceutical products and preparations which led to several epidemics:

4.4.1 Most IV-associated infections result from microbial contamination of the cannula.

4.4.2 Poor aseptic technique.

4.4.3 Poor compliance with hand hygiene and garbing.

4.4.4 The use of contaminated single-dose vials (SDVs) and multi-dose vials (MDVs).

4.4.5 Unsafe use of injection practices, specifically the use of the same syringe with new needles for drawing fluid from a common vial.



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in ISO class 5 air cleanliness conditions, unless otherwise specified by the manufacturer.

- 5.1.2.6 Dedicate the use of MDVs to a single patient whenever possible. If MDVs must be used for more than one patient, they should be kept or accessed in the immediate patient treatment area (e.g., patient rooms, operating rooms)
- 5.1.2.7 Document the date, time and initial in all MDVs once opened or reconstituted.
- 5.1.2.8 Refrigerate any opened MDVs as recommended by the manufacturer.
- 5.1.2.9 Clean the rubber diaphragm of the MDVs with 70% isopropyl alcohol before inserting a device into the vial.
- 5.1.2.10 Access the MDVs with a sterile device each time.
- 5.1.2.11 Avoid touch contamination of the MDVs.
- 5.1.2.12 Discard MDV when empty, when suspected or visible contamination occurs, or when the manufacturer's expiration date (listed on the vial, e.g., 28 days) is reached.
- 5.1.2.13 Follow manufacturer's expiration date for MDVs without preservatives listed on the vial (e.g., 24 hours at room temperature or 72 hours in the refrigerator from first vial entry).

5.1.3 Engineering Controls

It is recommended that in preparing compound sterile procedures use a primary engineering control device (e.g., laminar air flow workbench or biological safety cabinet (BSC) capable of maintaining International Organization for Standardization (ISO) class 5 (no greater than 100 particles per cubic foot or 3,520 particles per cubic meter) air cleanliness conditions.

- 5.1.3.1 Use of the laminar air flow hood (LAFH)
 - 5.1.3.1.1 Operate the LAFH continuously. Before processing sterile products, the hood should be running for a period of time long enough to purge room air from the work area (at least 30 minutes or as per the manufacturer's recommendations).
 - 5.1.3.1.2 Do not disrupt the air flow between the HEPA filter and any sterile objects to avoid contamination.
 - 5.1.3.1.3 Complete all work at least 6 inches from the edge in the interior of the LAFH.
 - 5.1.3.1.4 Disinfect the work surfaces and all accessible interior surfaces of the hood with a hospital-approved disinfectant before beginning work.
 - 5.1.3.1.5 Clean the exterior surfaces of the hood daily with a hospital-approved disinfectant.
 - 5.1.3.1.6 Inspect the containers of the ingredients used to prepare the sterile product for defects, product integrity, and the expiration date.



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- 5.1.3.1.7 Do not use defective or expired products.
- 5.1.3.1.8 Defective products should be reported to the Ministry of Health using the Drug Quality Report.
- 5.1.3.1.9 Disinfect the entire surface of all ampoules, vials and containers with 70% isopropyl alcohol before entry into the LAFH and allow them to air dry.
- 5.1.3.1.10 Handle all ampoules, vials, needles and syringes in such a way as to maintain asepsis and avoid unnecessary turbulence within the LAFH.
- 5.1.3.1.11 Ensure certification of the LAFH annually, or more frequently as needed, and maintain certification records.
- 5.1.3.2 CSPs are classified into five general categories based on risk of microbial contamination to all compound sterile preparations. These are as follows:
- 5.1.3.2.1 Immediate use: CSPs prepared outside of an ISO 5 device, which are intended for immediate use.
- 5.1.3.2.2 Low-risk level with 12-hour beyond-use date: CSPs prepared in ISO class 5 air cleanliness conditions in an unclassified segregated compounding area with ambient air.
- 5.1.3.2.3 Low-risk level: CSPs prepared in ISO class 7 or 8 buffer areas. The compounding procedure involves simple aseptic manipulations using no more than three commercially available ingredients and not more than two entries into any one final container.
- 5.1.3.2.4 Medium-risk level: CSPs prepared under batch conditions (multiple individual doses) or CSPs for individual patients using more complex aseptic manipulations (e.g., parenteral nutrition (PN) solutions and patient-controlled analgesia) prepared in ISO 5 air cleanliness conditions in an ISO class 7 or 8 area.
- 5.1.3.2.5 High-risk level: CSPs prepared from non-sterile ingredients or non-sterile devices or prepared in air quality less than ISO class 5 air cleanliness.

5.1.4 Sterile Product Preparation Area

- 5.1.4.1 Separate the functional areas from other areas.
- 5.1.4.2 Should have a controlled air flow under positive pressure that should not be disrupted by air ducts, vents or excess traffic that could produce air currents, introducing contaminants.
- 5.1.4.3 Should be free of particle-shedding materials such as cardboard boxes or powdered gloves. Such materials should not be stored in any area surrounding the hood.
- 5.1.4.4 Should not have carpets, drapes or other particulate-shedding materials in the preparation area.
- 5.1.4.5 Should have minimal personnel traffic confined to those persons directly engaged in IV admixture procedures or their supervision.



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5.1.5 Quality Control Monitoring

- 5.1.5.1 Use single-dose vials whenever possible for admixing parenteral preparations.
- 5.1.5.2 Monitor the temperature of refrigerators used in pharmacy to store medications continuously and set alarms to indicate excessively high or low temperatures.
- 5.1.5.3 Examine the final sterile product for any leaks, cracks, turbidity or particulate matter.
- 5.1.5.4 Label all mixed parental fluids with the following information:
 - 5.1.5.4.1 Patient Name (for patient-specific products).
 - 5.1.5.4.2 Medical record number, patient location.
 - 5.1.5.4.3 Solution and ingredient names and concentrations.
 - 5.1.5.4.4 The administration regimen names and concentrations.
 - 5.1.5.4.5 The expiration date and time.
 - 5.1.5.4.6 Storage requirements.
 - 5.1.5.4.7 Identification of the responsible pharmacist by badge number.
 - 5.1.5.4.8 Appropriate additional labeling, such as any precautionary measures that need to be taken.
 - 5.1.5.4.9 Device-specific instructions.
 - 5.1.5.4.10 Any additional information in accordance with local regulations or requirements.

5.1.6 Storage

The Pharmacy is responsible for the appropriate storage of pharmaceuticals throughout the institution. The following applies to parenteral admixtures:

- 5.1.6.1 Store parenteral admixtures according to the manufacturer's recommendations.
- 5.1.6.2 Remove expired medication from patient care areas, and ensure its proper disposal.
- 5.1.6.3 Store admixed parenteral solutions in the refrigerator for up to 1 week, provided that refrigeration begins immediately after preparation and is continuous. The stability of admixed ingredients may dictate a shorter or longer refrigeration period.
- 5.1.6.4 Check the temperature of refrigerator used to store pharmaceuticals daily (twice, if used to store vaccines). The temperature recorded electronically or on a log that is dated and signed by the person performing the temperature check.



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5.1.6.5 Maintain room temperature between 20 to 25°C.

5.1.6.6 Strictly follow manufacturer's recommendation for storage and handling of medications.

5.2 Pharmacy Responsibilities Involving Antimicrobial Control

Concerns about antimicrobial resistance causing increased morbidity, mortality and healthcare costs have led to recommendations for controlling antimicrobial use.

5.2.1 Establish a system to control and monitor antimicrobial usage.

5.2.2 Participate in the development of programs for formulary and antimicrobial control.

5.2.3 Collaborate with physicians regarding patient-specific recommendations for optimal antimicrobial use.

5.3 Preparation of Compounded Sterile Preparations in Patient Care Areas Outside the Pharmacy

Preparing IV medication outside the Pharmacy do not typically use a primary engineering control device (e.g., laminar airflow workbench), thus individuals mixing CSPs must be trained and must follow the following recommendations:

5.3.1 Follow aseptic technique when preparing CSPs.

5.3.2 Use immediately any CSPs prepared outside an ISO 5 device.

5.3.3 Follow the same recommendation mentioned above regarding the use of SDVs and MDVs and for storing medications.

5.3.4 Administration of IV medications:

5.3.4.1 Disinfect the IV access port prior to administration of the medication or solution.

5.3.4.2 Administer medication according to the six rights of medication administration (i.e., name of medication, route, time, patient, dosage, and documentation).

5.3.4.3 Do not administer any medication prepared by another practitioner.

5.3.5 Follow safety precautions when handling sharp items:

5.3.5.1 Dispose needles/sharps at the point of use in a leak-proof, puncture-resistant sharp container with the biohazard label.

5.3.5.2 Do not recap needles.



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5.3.5.3 Replace sharp container when $\frac{3}{4}$ full.

6. ATTACHMENT

6.1 N/A

7. REFERENCES

- 7.1 Association for Professionals in Infection Control (APIC) and Epidemiology, Inc. (2014). Chapter 30: Aseptic technique. In APIC Text of infection control and epidemiology (4th ed.).
- 7.2 Association for Professionals in Infection Control (APIC) and Epidemiology, Inc. (2014). Chapter 110: Pharmacy services. In APIC Text of infection control and epidemiology (4th ed.).
- 7.3 In 2004, the United States Pharmacopeial (USP) Convention published the first national standards and enforceable standards for compounded sterile preparations (CSP) to protect patients against preventable harm (i.e., General Chapter 797-Pharmaceutical Compounding-Sterile Preparations).

8. APPROVAL

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	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021
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1.0. PURPOSE

- 1.1. To provide guidelines on proper infection control practices in LABORATORY DEPARTEMENT

2.0. DEFENITION

- 2.1. To establish guidelines that would assist in minimizing or preventing the transmission of infectious agents in the laboratory.

3.0. RESPONSIBILITY

- 3.2.LABORATORY staff

4.0. POLICY

- 4.1. The laboratory is a unique work environment that may pose infectious disease threats to those who work there.
- 4.2. Biosafety levels were established to ensure that the laboratory environment is adequately equipped with measures to ensure safety of those working in them or the surrounding environment.
- 4.3. Special procedures are used to ensure the safe handling and transport of biohazardous waste.
- 4.4. Being one of the largest generators of infectious waste in the healthcare setting, specific procedures exist for laboratory infectious waste management.
- 4.5. Laboratorians should be an integral part of an infection prevention program. The microbiology laboratory helps detect and identify microorganisms so that the infection control team can monitor, prevent, and control infection transmission.

5.0. PROCEDUREs

5.1. Biological Risk Assessment

Each clinical laboratory should perform a biological risk assessment on an annual basis or any time a new risk is identified. It is a process used to identify the hazardous characteristics of known infectious or potentially infectious agent or materials; the activities that can result in a person's exposure to an agent; and, the likelihood that such exposure will cause laboratory acquired infections (LAIs).

The primary factors in the risk assessment and selection of precautions fall into two broad categories: agent hazards and laboratory procedure hazards. Although there is no



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standard approach for conducting biological risk assessment, the Biosafety in Microbiological and Biomedical Laboratories (BMBL) documents suggest a five-step approach to prevent LAIs.

- 5.1.1. Identify agent hazards and perform an initial assessment of risk:
 - A. Review potential biological agents and their hazardous characteristics.
Hazardous characteristics include their capability to infect and cause disease in a susceptible human host, severity of disease, the availability of preventive measures.
 - B. Implement regulations that govern the possession, use, and transfer of these types of biological agents and toxins that have the potential to pose a severe threat to public health and safety.
- 5.1.2. Identify laboratory procedure hazards
Procedure hazards often found in a clinical lab include agent concentration, suspension volume, equipment and procedures that generate small-particulate aerosols and larger airborne particles (droplets), complexity of lab procedures, and use of sharps.
- 5.1.3. Make a final determination of the appropriate biosafety level and select additional precautions indicated by the risk assessment.
- 5.1.4. Evaluate the proficiencies of staff regarding safe practices and the integrity of safety equipment.
 - a. Evaluate the laboratorian's training and experience in handling infectious agents.
 - b. Proficiency in the use of sterile techniques and Biological Safety Cabinet (BSC).
 - c. Ability to respond to emergencies and willingness to accept responsibility for protecting one's self and others.
- 5.1.5. Review the risk assessment with a biosafety professional subject matter expert and the institutional biosafety committee.
Once the risk assessment is completed it should be reviewed by site-specific, and if necessary, local experts in biosafety. This review should include the Infection Preventionist (IP), laboratory safety, and infection prevention and control committee, as well as, Safety Committee.

5.2. Standard Microbiological Practices, Safety Equipment, and Facility Safeguards

- 5.2.1. Standard microbiological practices
 - 5.2.1.1. The laboratory supervisor must enforce the institutional policies that control access to the laboratory.
 - 5.2.1.2. Personnel must wash their hands after working with potentially hazardous materials and



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before leaving the laboratory.

- 5.2.1.3. Do not permit eating, drinking, smoking handling contact lenses, applying cosmetics, and storing food for human consumption in laboratory areas.
- 5.2.1.4. Prohibit mouth pipetting; use mechanical pipetting devices.
- 5.2.1.5. Develop and implement policies for the safe handling of sharps (e.g., needles, scalpels, pipettes, broken glassware). Whenever practical, laboratory supervisors should adopt improved engineering and work practice controls that reduce risk of sharp injuries. Follow precautions below when dealing with sharps:
 - A. Do not bend, shear, break and recap needles nor remove from disposable syringes, or otherwise manipulate by hand before disposal.
 - B. Place used disposable needles in conveniently located puncture-resistant sharp containers.
 - C. Do not handle broken glassware directly by hands; it must be removed using a brush and dustpan, tongs or forceps. Substitute plastic ware for glassware whenever possible.
- 5.2.1.6. Perform all procedures to minimize the creation of splashes and/or aerosols.
- 5.2.1.7. Decontaminate work surfaces after completion of work and after any spill or splash of potentially infectious material with appropriate disinfectant.
- 5.2.1.8. Decontaminate all cultures, stocks, and other potentially infectious materials before disposal using an effective method. Depending on where the decontamination be performed, the following methods should be used prior to transport:
 - A. Place in durable, leak proof container all materials to be decontaminated outside of the immediate laboratory and secure for transport.
 - B. Pack materials in accordance with local and state regulations.
- 5.2.1.9. Post the universal sign symbol at the entrance to the laboratory when infectious agents are present. Posted information must include the laboratory biosafety level, the supervisor's name (or other responsible personnel), the telephone number, and required procedures for entering and exiting the laboratory.
- 5.2.1.10. Develop an effective pest management program.
- 5.2.1.11. The laboratory supervisor must ensure that laboratory personnel receive appropriate training regarding their duties, the necessary precautions to prevent exposures, and exposure evaluation procedures.
- 5.2.2. Special practices
 - 5.2.2.1. Advise all persons entering the laboratory of the potential hazards and meet specific entry/exit requirements.
 - 5.2.2.2. Provide laboratory personnel with medical surveillance and offer appropriate



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DPP

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immunizations for agents handled or potentially present in the laboratory.

- 5.2.2.3. Store a baseline serum sample.
- 5.2.2.4. Prepare and adopt as a policy a laboratory-specific biosafety manual. The biosafety manual must be available and accessible.
- 5.2.2.5. The laboratory supervisor must ensure that laboratory personnel demonstrate proficiency in standard and special microbiological practices before working with Biosafety Level (BSL-2) agents.
- 5.2.2.6. Place potentially infectious materials in a durable leak-proof container during collection, handling, processing, storage, or transport within a facility.
- 5.2.2.7. Decontaminate laboratory equipment routinely, as well as after spills, splashes, or other potential contamination.
- 5.2.2.8. Evaluate and treat immediately any incidents that may result in exposure to infectious materials according to procedures described in the laboratory biosafety manual. All such incidents must be reported to the laboratory supervisor. Provide medical evaluation, surveillance, and treatment and maintain appropriate records.
- 5.2.2.9. Do not permit animals and plants not associated with work being performed in the laboratory.
- 5.2.2.10. Conduct all procedures involving the manipulation of infectious material that may generate an aerosol within a biosafety cabinet (BSC) or other physical containment devices.

5.3. Safety Equipment (primary barriers and PPE)

- 5.3.1. Use properly maintained BSCs (preferably Class II), other appropriate PPEs, or other physical containment devices whenever:
 - A. Procedures with potential for creating infectious aerosols or splashes are conducted. These may include pipetting, centrifuging, grinding, blending, shaking, mixing, sonicating, opening containers of infectious materials, inoculating animals intra-nasally, and harvesting infected tissues from animals or eggs.
 - B. High concentrations or large volumes of infectious agents are used. Such materials may be centrifuged in the open laboratory using sealed or rotor heads or centrifuge safety cups.
- 5.3.2. Wear protective laboratory coats, gowns, smocks, or uniforms designated for laboratory use while working with hazardous materials. Remove protective clothing before leaving for non-laboratory areas (e.g., cafeteria, library, administrative offices).
- 5.3.3. Wear eye and face protection (goggles, mask, face shield, or other splatter guard) for anticipated splashes or sprays of infectious or other hazardous materials when handling microorganisms outside the BSC or containment



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device. Persons wearing contact lenses should also wear eye protection.

- 5.3.4. Wear gloves to protect hands from exposure to hazardous materials. Select gloves based on an appropriate risk assessment. Alternative to latex gloves must be available. Do not wear gloves outside the laboratory. In addition, BSL-2 laboratory workers should:

- Change gloves when contaminated or when integrity has been compromised.
- Remove gloves and wash hands when work with hazardous materials has been completed and before leaving the laboratory.
- Do not wash or reuse disposable gloves Use eye, face and respiratory protection in rooms containing infected animals as determined by the risk assessment.

5.4. Laboratory Facilities (secondary barriers)

- Laboratory doors should be self-enclosing and have locks in accordance with institutional policies.
- Laboratory must have sink for hand washing. The sink may be manually, hands free, or automatically operated. It should be located near the exit door.
- The laboratory should be designed so that it can be easily cleaned and decontaminated. Carpets and rugs are not permitted.
- Laboratory furniture must be capable of supporting anticipated loads and uses. Spaces between benches, cabinets, and equipment should be accessible for cleaning.
 - Bench tops must be impervious to water and resistant to heat, organic solvents, acids, alkalis, and other chemicals.
 - Hairs used in laboratory must be covered with a nonporous material that can be easily cleaned and decontaminated with appropriate disinfectant.
- Laboratory windows that open to the exterior are not recommended. However, if a laboratory does have windows that open to the exterior, they must be fitted with screens.
- BSC must be installed so that fluctuations of the room air supply and exhaust do not interfere with proper operations. BSC should be located away from doors, windows that can be opened, heavily traveled laboratory areas, and other possible airflow disruptions.
- Vacuum lines should be protected with HEPA filters or their equivalent. Filters must be replaced as needed. Liquid disinfectant traps may be required.
- An eyewash station must be readily available.
- Clinical laboratories must maintain proper handling according to the procedures they are performing. Typically, a clinical lab has negative airflow to the adjacent areas. Specialized areas such as rooms where polymerase chain reaction (PCR) may need positive air pressure to limit potential RNA contamination of the reagents. Facilities should consider mechanical ventilation systems that provide an inward flow of air without recirculation to space outside laboratory.
- HEPA-filtered exhaust air from a Class II BSC can be safely recirculated back into the laboratory environment if the cabinet is tested and certified at least annually and operated according to



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manufacturer's recommendations.

- 5.4.11. A method for decontaminating all laboratory wastes should be available in the facility (e.g., autoclave, chemical disinfection, incineration, or other validated decontamination method).

5.5. Laboratory Equipment

There are three general types of BSCs: Classes I, II, and III. All BSCs must be recertified annually by an independent professional.

- 5.5.1. **Class I BSC** – this cabinet is like a chemical fume hood and has an inward airflow through the front opening. Exhaust air from the BSC is passed through a HEPA Filter so that the equipment protects both worker and the general public. However, the specimen and other materials are potentially subject to contamination. Class I are not generally recommended for work that involves biohazardous material.
- 5.5.2. **Class II BSCs** - designed to protect the worker, the general public, and the specimen. Airflow velocity at the face of the work opening is at least 75 linear ft/min (lfpm). Both the supply air and exhaust air are the HEPA-filtered. There are four types of Class II BSCs (IIA, IIB2, and IIB3). They differ in the amount of recirculation, down flow, and inflow. Usually, all but IIA are considered satisfactory for biohazardous and toxic agents.
- 5.5.3. **Class III BSCs** – are totally enclosed, ventilated cabinets of gas-tight construction that offer the highest degree of protection from infectious aerosols. They also protect research materials from biological contamination. Class III BSCs are most suitable to work with hazardous agents that require containment at BL-3 or BL-4. All operations in the work area of the cabinet are performed through attached rubber gloves. The cabinets are operated under negative pressure. Supply air is HEPA filtered, and the cabinet exhaust air is filtered by two HEPA filters in series or HEPA filtration followed by incineration before discharge outside of the facility. The CLASS II BSC must be connected to double- door autoclaves and chemical dunk tanks to permit sterilization or disinfection of all materials before leaving the cabinet and also to allow supplies to enter the cabinet.
- 5.5.4. Centrifuges are commonly used in the clinical laboratory as part of specimen processing. Hazards associated with centrifuging include mechanical failure (e.g. rotor failure, tube or bucket failure) and the creation of aerosols. Use safety precautions to decrease the risk and associated with centrifugation. Examples of these precautions include:
- Use sealed tubes and safety buckets that seal with O-rings.
 - Filling open centrifuge tubes, rotors, and accessories in a BSC.
 - Always balance buckets, tubes, and rotors properly before centrifugation.
- 5.5.5. Phlebotomy in most hospital setting, the laboratory is responsible for most phlebotomy procedures. Handle all body fluids using standard precautions.
- Wear gloves when performing venipuncture.
 - Wear other protective equipment such as goggles, mask or lab coat for a



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procedure based on the risk of exposure (i.e., arterial punctures).

- c. Always use safe needles.
- d. Use only single-use disposable tube holders.
- e. Dispose all phlebotomy needles promptly in a puncture-resistant container to prevent their reuse or accidental injury to a handler.

5.6. Transporting Biohazardous Waste Materials

Laboratories often need to transport biohazardous materials offsite. This transport may be across campus, cross town to another laboratory. Personnel who package and ship these specimens must be concerned with their safety and the protection and safety of those who receive the material.

- 5.6.1. Meet packaging standards for samples transported by local carriers such as cabs, hospital, and clinical vehicles, or personal cars.
- 5.6.2. The requirements for shipping biohazard materials interstate or intrastate depend on the type and volume of specimen. The regulations define three types of specimens:
 - a. Biological products—are finished biological substances for veterinary or human use such as vaccines and reagents. These products must meet public health standards (9 CFR Parts 102-104 and 21 CFR Parts 312 and 600-680).
 - b. Diagnostic (clinical substances)—comprises excreta, secretions, blood and its components, as well as tissue and tissue fluids that are being shipped for diagnostic purposes.
 - c. Infectious (etiological) substances—include organisms known to be pathogenic to humans and clinical samples with a high likelihood of being infectious. Infectious substance could include clinical specimens such as enzyme immunoassay (EIA), HIV-positive serum submitted for Western blot analysis, and sputum samples from patients known to be culture-positive for tuberculosis.
- 5.6.3. The essential element for protection is the triple-containment packaging, which is required for shipping each of these substances. In all categories and volumes, there must be a primary container accompanied by enough absorbent material to contain the whole sample, a waterproof container, and an outer container. The packaging is expected to be able to withstand rough handling and passage through cancellation machines, sorters, and conveyors throughout the transport. The sample identification document must be located outside the secondary containment. Additionally, labels clearly marking the biohazard level must be prominently displayed on the outside container. Depending on the level of biohazard, additional labels and information may need to be displayed, as well.

5.7. Infectious Waste Management



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Steam autoclave is the method of choice for decontaminating discarded cultures. If laboratory wastes must be stored before disposal, storage should be as brief as possible. The site must be properly identified with a biohazard label, have restricted access, and be located near the site of generation.

Clean the areas thoroughly each time it is emptied of waste contents. Refer to policy of (Management of Infectious Waste.)

5.8. Infection Prevention and Occupational Exposures

The goal of occupational health in a clinical lab and in university research laboratories is to promote a safe and healthy workplace. Educate laboratory workers about the biohazards to which they may be occupationally exposed.

- 5.8.1. Provide workers who may be exposed to highly pathogenic agents such as in a clinical research lab a pre-placement medical evaluation. The workers' supervisors should provide his staff a description of the requirements for the position and an understanding of the potential hazard present in the work environment.
- 5.8.2. The healthcare provider should review the worker's previous and ongoing medical problems, current medications, allergies to medicines, animals, and other environmental proteins, and prior to immunizations
- 5.8.3. Provide vaccines to workers to protect them against infectious agents to which they may be occupationally exposed.
- 5.8.4. Encourage workers to seek medical evaluation for symptoms that they suspect may be related to infectious agents in their work area without fear of reprisal. A high index of suspicion for potential occupational exposures should be maintained during any unexplained illness among workers or visitors to worksites containing biohazards.
- 5.8.5. Report all occupational injuries to Employee Clinic or Occupational Health Department.

6.0. ATTACHMENT



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6.1. N/A

7.0. REFERENCES

7.1. The GCC Infection Prevention Control Manual 3rd Edition

8.0. APPROVAL

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1.0.PURPOSE

- 1.1.To provide guidelines on proper infection control practices in EMERGENCY MEDICAL SERVICES / AMBULANCE SERVICES DEPARTEMENT

2.0.DEFENITION

- 2.1.This document provides Emergency Medical Service (EMS) providers in implementing best infection prevention and control recommendations and practices in their daily routines and work environment, and protect EMS providers, patients, and other healthcare workers from potential infections.

3.0.RESPONSIBILITY

- 3.1.emergency medical staff
3.2.emergency nursing staff
3.3.emergency transportation staff

4.0.POLICY

- 4.1.Emergency Medical Service (EMS) is at the front line of medical care, having high risk of exposure to patients with known or unknown infectious diseases.
- 4.2.Emerging pathogens and antimicrobial-resistant strains are major problems facing all healthcare providers, including EMS providers.
- 4.3.The ambulance is a mobile patient care environment. It is generally divided into two spaces: the driver area and the patient care area. Patient care equipment are stored in enclosed compartments in the ambulance. Air circulation in the vehicle is generally rapid, low-velocity airflow. Some ambulances have built-in high-efficiency particulate air (HEPA) filters which vary among ambulance manufacturers. There is also an exhaust fan to assist in air exchange. These air handling systems basically place EMS providers at low-risk for Mycobacterium Tuberculosis (MTB). The floor and walls of the ambulance are constructed for ease of cleaning.



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5.0.PROCEDURE

5.1. En Route Communication

1. As part of the initial response protocol, most communication dispatch centers will provide basic incident information to the responding units. Instruct all providers to adhere to Standard Precautions, which include treating all patients and body fluids as potentially infectious. Transmit information suggestive of an airborne/droplet disease.
2. EMS personnel will give the Emergency Department (ED) the patient history, physical assessment, vital signs, medication listing, and all elements of care provided during the transport.

5.2. Field Care

Care is frequently in the outdoors and in all types of weather and circumstances. Such circumstances may increase the risk for patient infection because of wound contamination or equipment contamination at the location. Due to the environment in which care must be rendered, Intravenous (IV) starts and wound care may be undertaken in less-than-ideal (aseptic) conditions.

1. Exert all efforts in properly preparing the insertion site for IV start.
2. Instruct field personnel to communicate to the ED when circumstances of IV access have been particularly difficult.
3. Generally, remove IV lines and dressings placed in the field in the ED and replace within 24 hours.
4. ED staff need to assess each patient carefully for wound contamination (i.e., oil, chemical, debris) in all patients transported from an accident scene.
5. Endotracheal tubes and laryngoscopes are used under difficult conditions in most cases. Blades and scopes are stored in a variety of ways:
 - a. Employ a method of storing and carrying equipment in a way that would minimize potential contamination and compromise of aseptic field.
 - b. Clean and disinfect non-disposable blades using high level disinfection. Refer to Sterile Supplies and Equipment Management.
6. Follow safe injection practices.
7. Consider newer airway management equipment and procedures that reduce the complications of infections, such as the use of non-invasive ventilators like the continuous positive airway pressure (CPAP) devices.

5.3. Use of personal protective equipment (PPE)

(Refer to Standard Precautions)



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5.4. Multi-patient or mass casualty incidents

When faced with a multi-patients or mass casualty incident, providers should attempt to adhere to the basic principles of infection prevention: prevent contamination and exposure of the provider to the body fluids of the patient(s).

Infection prevention consideration should stress steps that providers can implement to deal with the need to rapidly change gloves as follows:

1. Place additional spare gloves in a fanny pack or pants.
2. Make sure that any open areas on hands or arms are covered with an occlusive dressing.
3. Apply three or four pairs of gloves and use a shedding process of removing the top layer as it becomes overly soiled with liquefied body fluids or the structural integrity of the glove is recommended.
4. Use 4x4 in. gauze to wipe the accumulated fluid from the gloves to decrease cross-contamination to the next patient.

5.5. Bioterrorism

EMS providers play an important role in identifying potential outbreaks, by raising the index of suspicion as early as possible upon contact with a patient and upon recognizing an increased number of patients with similar response so isolation can begin.

1. Apply appropriate use of PPEs, proper patient packaging, and early facility notification.
2. Plan to maintain a large-volume contingency inventory of PPEs and ensure that PPE is used appropriately for patient.
3. Train EMS personnel to assess patients for signs and symptoms of biological illnesses by focusing on obtaining a good patient history, including travel history.
4. Have a heightened level of suspicion to the signs and symptoms of communicable disease, particularly when other cases present with similar symptoms.
5. Develop a mechanism to ensure that information is shared with the transporting unit, the receiving medical facility, and the appropriate health department.
6. On arrival at the medical facility, the EMS providers should disembark the patient only when it is clear where the patient will be taken.



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5.6. Ambulance Cleaning and Disinfection

Cleaning is the physical removal of foreign and organic materials on objects or surfaces with the use water, soap or detergents, and mechanical friction (scrubbing action).

Disinfection is the process that kills and prevents microbial growth on surfaces and equipment using appropriate disinfectants.

1. After the patient has left and prior to cleaning, exhaust the air within the patient care compartment by opening the doors and windows of the vehicle while ventilation system is running. This should be done outdoors and away from pedestrian traffic.
2. Wear PPEs prior to start of cleaning session.
3. In decontaminating an ambulance, thorough cleaning must be performed first before effective disinfection can take place.
 - i. Remove visible soil, blood, and other organic debris from the item or surface before applying disinfectant.
 - ii. Clean and disinfect items and surfaces as soon as possible after use.
 - iii. Focus on high-risk (frequently-touched) items/surfaces in the patient-care compartment that have been directly or potentially contaminated with blood or body fluids during patient care, followed by low-risk (non-frequently touched) surfaces.
 - iv. Clean and disinfect non-patient care areas of the vehicle (driver's compartment) may become indirectly contaminated as per vehicle manufacturer's recommendations.
 - v. Wear gloves when using disinfectants and immediately perform hand hygiene after glove removal.
 - vi. Place in a clearly marked biohazardous bags contaminated reusable patient care equipment and devices for appropriate cleaning, disinfection and/or sterilization. Clean and disinfect these items according to manufacturer's recommendations.
 - vii. Manage spills of blood or bodily fluids as per institutional policy (see Management of Infectious Waste).
 - viii. Contaminated linen should be appropriately bagged and sent to laundering facility.
 - ix. After cleaning, remove and dispose PPE in a leak-proof bag or waste container. Immediately perform hand hygiene. Avoid touching face with gloved or unwashed hands.
4. High-risk objects/surfaces are frequently touched with hands (both gloved and ungloved), therefore are the most contaminated parts of the ambulance. They require cleaning and disinfection between every patient encounter or use at most. Examples are, but not limited to:



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- x. Stretchers /railings;
 - xi. Door handles;
 - xii. Stethoscopes;
 - xiii. Electronic patient care equipment and control panels;
 - xiv. Steering wheels;
 - xv. Radios/Cellphones;
 - xvi. Light switches;
 - xvii. Adjacent flooring, walls, and ceilings; and
 - xviii. Handles, outer surfaces of cabinets/compartments where medical equipment are stored.
5. Low-risk objects/surfaces are minimally contacted with hands. They require cleaning and disinfection on a regular basis or when contamination occurs. Examples are, but not limited to:
- i. Other floor, walls, ceiling surfaces;
 - ii. Windows; and
 - iii. Inner surfaces of cabinets/compartments where medical equipment are stored.
6. Wipe down equipment that was in contact with a patient before the next call, focusing on what was used or what was in contact with the patient during care.
7. Clean the entire ambulance at the end of the day. The entire vehicle may be emptied on regular intervals (i.e., weekly).
8. Use disinfectants according to manufacturers' instructions. Adhere to recommended contact/kill times (length of time the disinfectant must remain on object/surface). Adhere to safety precautions (PPE use, adequate ventilation, proper disposal, etc.) as directed.
9. Clean and dry reusable cleaning equipment after use, disposable items such as wipes can be disposed as general waste.
- Maintain a cleaning plan, schedule log, or checklist**



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5.7. Infection Prevention and Control Recommendations for Patients Hands-off or Transfer

The primary objective of a hand-off is to provide accurate information about a patient's current conditions, care and treatment received to prevent transmission of infection.

1. Develop an inter-facility transfer procedure that establishes practical and effective measures for isolating the disease organisms, not the patient.
2. Communication between EMS and hospital/facility staff.
3. Safe and effective transport of patients on isolation precautions begins with identification and communication of these precautions to all healthcare workers involved in the transfer process.
 - i. Determine if a patient is on isolation precautions prior to patient contact. This may require requesting additional information from facility staff.
 - ii. Request as much information as possible related to the patient's isolation status, including information related to:
4. Presence of the following signs and symptoms: cough (especially productive), bowel and urinary incontinence, vomiting, rashes, open or weeping wounds, fever.
5. Special isolation precautions and recommended PPEs.
6. Additional information related to patient's condition.
7. When transporting a patient with suspected or confirmed infection, EMS providers should ALWAYS convey the above information to the receiving facility immediately upon arrival.
8. Transport of patients on Isolation Precautions.
9. In order to reduce spread of infection, observe Standard Precautions at all times, regardless of the patient's infection status. Refer to ICM-II-03 Standard Precautions.
10. Alcohol-based hand rub must be made available to ensure proper hand hygiene on events at which water is not readily available.
 - i. In some cases, Isolation Precautions are required in addition to Standard Precautions. Refer to Isolation System: A Quick Reference Guide.
 - ii. If patient to be transported can tolerate a face mask, its use can help minimize spread of infectious droplets in the patient care compartment. Patients exhibiting acute respiratory distress should be administered oxygen via a non-rebreather mask.



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11. Infection prevention and control transport tools
12. To promote effective communication between the facility and EMS providers, provide guidelines for the identification or flagging patients on isolation precautions and the appropriate PPEs needed for patient transport. EMS can request a facility staff to complete this tool prior to patient contact.
13. This tool can be modified to meet organizational needs.

5.8. EMS Provider Vaccination and Testing Recommendations

Due to frequent contact with many patients, EMS providers are at risk for exposure to, and possible spread of, vaccine-preventable diseases. Therefore, it is imperative that EMS providers participate in a comprehensive healthcare personnel immunization and TB screening program. Refer to *Immunization Guidelines for Healthcare Workers and Contact Tracing, Screening and Treatment of MTB in Healthcare Workers*.

5.9. Staff Education

EMS personnel should undergo regular infection prevention and control education sessions for continuing education and skills appraisal. EMS personnel must have basic knowledge on preventing and controlling spread of infectious agents, as well as the ability to implement them during the course of their duty.

Records of staff attendance must be documented and filed

6.0. ATTACHMENT

6.1. N/A

7.0. REFERENCES

7.1. The GCC Infection Prevention Control Manual 3rd Edition



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	Ms. Aisha Khubrani	Quality Director		13-7-2021
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	TITLE:	IPC IN RESPIRATORY THERAPY SERVICES	
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1.0.PURPOSE:

- 1.1.To describe infection control standards for respiratory therapy services and to avoid any improper handling of respiratory care equipment that may lead to increased incidence of healthcare – associated infections.

2.0.DEFINITION

2.1.N/A

3.0.RESPONSIBILITY

- 3.1.RT team
- 3.2.Staff nurse
- 3.3.CSSD staff

4.0.POLICY

- 4.1.Certain interventions used by Respiratory Care Service may influence infection risks to patients and HCWs.
- 4.2.Mechanical ventilation, ventilator circuits channels, handling of condensate, use of nebulizers, suction catheters and humidification methods are potential infection risks
- 4.3. Routes of transmission of pathogens most commonly associated with respiratory care are airborne, droplet nuclei and direct contact with contaminated fluids such as secretions, saliva, sputum, blood or condensate in aerosol tubing or a ventilator circuit.
- 4.4.Transmission of pathogens in fluid occurs when the fluid physically moves, flows, or spills from one area to another.
- 4.5.Direct contact with hands or equipment is thought to be the common mode of transmission.
- 4.6.Routes of transmission may be from practitioner or device to patient, from one patient to another, or from one body site to the lower respiratory tract of the same patient, via the hands or device
- 4.7.Nebulizers with reservoirs can allow the growth of hydrophilic bacteria that can be nebulized to



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the patient during device care.

4.8. Gram – negative bacilli such as *Pseudomonas* spp., *Stenotrophomonas* spp., *Flavobacterium* spp., *Legionella* spp., and non – tuberculosis mycobacteria can multiply to substantial concentrations in nebulizer fluid and increase the risk of acquiring pneumonia.

4.9. Sterilization or high level disinfection can eliminate vegetative bacteria from device reservoirs making the reservoirs safe for patient use.

4.10. Improved VAP incidence has been reported when using a closed suction versus an open suction system. Elimination of routine closed – system suction catheter changes increases safety and reduces the costs of mechanical ventilation

5.0. PROCEDURE:

5.1. Standard precautions

1. Use standard precautions for all patient care. Refer to policy of Standard Precautions.
2. Use personal protective equipment (PPE) singly or in combination for any or all of the following procedures as indicated:
 - a. Wear gloves for handling respiratory secretions and objects contaminated with the respiratory secretions of any patient.
 - b. Wear face protection (mask and goggles) when contamination of the face with aerosolized particles is likely.
 - c. Wear an N95 particulate mask or a power air purifying respirator (PAPR) when managing patients with suspected or confirmed pulmonary tuberculosis. Refer to Management of Suspected / Confirmed Cases of Infectious Mycobacterium Tuberculosis.
3. Wear PPE when contact with the respiratory secretions from a patient is likely.
 - a. Change the PPE after such contact and before providing care to another patient.
4. Follow the required isolation precautions when entering the rooms of patients in isolation. Refer to protocols in the following policy of isolation Contact Isolation, Droplet Isolation, Airborne Isolation Precautions.



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5. Respiratory equipment (e.g., ventilator, monitors, etc.) in use should be cleaned regularly (when visibly soiled, daily, and when patient is discharged) to reduce environmental contamination.
6. All reusable respiratory items requiring disinfection and sterilization must be sent to the Central Sterile Supply Department (CSSD).

5.2. Hand hygiene

1. Wash or cleanse hands and dry them thoroughly before and after all contacts with the patient and the patient's environment; refer to policy on Hand Hygiene.
2. Wash and dry or cleanse hands before and after glove use.

5.3. Mechanical ventilation and humidifiers

1. Use high-efficiency bacterial filters in the breathing circuit of the ventilation unit.
2. Ensure that the patient is positioned with his/her head elevated at a 30° to 45° angle, except during postural drainage procedures, to minimize aspiration of secretions.
3. Use filters on the inspiratory limb to eliminate contaminants from entering the inspired gas and contaminating the ventilator.
4. Place bacterial filters appropriately to avoid any potential interference with the operating characteristics of the ventilator by impeding high gas flow.
5. Carefully test reusable filters periodically to ensure efficient functioning.
 - a. These filters must be reprocessed by CSSD.
6. Use closed continuous-feed humidification on all ventilator circuits to minimize/prevent aerosols, thus preventing the transmission of bacteria from the humidifier reservoir to patients.
7. Use sterile water to fill humidifiers. Heated humidification systems often operate at temperatures that reduce or eliminate bacterial pathogens. Tap or distilled water may harbor *Legionella* spp. that is more heat-resistant than other bacteria.
8. Sterilization or high-level disinfection of reusable circuits, humidifiers and nebulizers between patients is recommended.
9. Disinfect in-line temperature sensors properly according to the manufacturer.
10. The ventilator circuit, including the ventilator tubing and filter, exhalation valve and humidifier, should be changed when visibly soiled or mechanically malfunctioning.
 - a. No maximum time between changes has been recommended for use of ventilator circuits with non-aerosol-generating humidifiers.



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- b. Circuits should not be routinely changed for infection control purposes. Increased VAP infection rates are associated with 48-hour circuit changes.
- c. HMEs should be changed if there is gross contamination or mechanical malfunction.

5.4. Artificial Airways

1. Elevate the patient head's between 30° and 45°, during the use of artificial airways, especially during feedings and for one hour following feedings, when not contraindicated.
2. Do not routinely deflate the cuff of the endotracheal tube to determine the filling volume of the cuff. Alternative techniques to assure proper cuff pressure (such as minimal leak or minimal occluding pressure) should be used.
3. Ensure proper cuff pressure with minimal leak or minimal occluding pressure.
4. Perform a tracheostomy when indicated using sterile technique. Elective tracheostomy should be performed in the operating room.
5. Use aseptic technique to change the airway tube.
6. Replace the tube with one that has undergone sterilization or high-level disinfection.

5.5. Condensate

1. Drain and discard any condensate that collects in the tubing of the ventilator to prevent it from draining toward the patient.
2. Use water traps to minimize spillage.
3. Place traps appropriately in the ventilator circuits so as to allow gravity to drain condensate continuously away from the patient.
4. Treat contaminated condensate as waste and properly dispose of it through the standard hospital waste system.
5. Use heated wire circuits to reduce/eliminate condensate formation in the ventilator circuit.
6. Set heated wire circuits so that a small amount of condensate forms on the inspiratory limb of the circuit, indicating 100% relative humidity.
7. Adjust the heated wire circuit properly to deliver the appropriate humidity to the patient.
8. : Heat and moisture exchanger (HME) can increase dead space and resistance to breathing and, at the same time, provide less humidity than the active systems previously discussed, resulting in thick and obstructive secretions in some patients. To be effective, >70% of the gas entering the airway must be exhaled through the HME. Place HME between the ventilator circuit and the patient's airway.



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- If the humidity is decreased, it will result in damage to the epithelium of the respiratory tract, with potential occlusion of artificial airways, especially in infants and small children.
- There is no CDC recommendation for preferential use of HME rather than heated humidifiers to prevent healthcare-associated pneumonia.
- The HME should be changed when grossly contaminated or mechanically malfunctioning.
- Vent circuits should not routinely be changed when using an HME.

5.6. Nebulizers

- Large-volume nebulizers and mist tents:

Room humidifiers that create aerosols have been associated with nosocomial pneumonia secondary to contamination of their reservoirs. The CDC recommends that aerosol-generating room humidifiers not be used unless they can be filled only with sterile fluids and be sterilized or undergo high-level disinfection every 24 hours.

- Reusable large-volume nebulizers, mist tents, and hoods should be subject to sterilization or high-level disinfection between patients and after every 24 hours of use on the same patient.
 - Change disposable large-volume nebulizers every 72 hrs.
- Small-volume medication nebulizers - handheld and inline:
 - Use only sterile fluids that are dispensed aseptically.
 - Disinfect or sterilize nebulizers between patients.
 - Single-dose vials are preferred over multi-dose vials.
 - Disinfect and rinse nebulizers with sterile water and air dry after each treatment on the same patient.
 - Aseptically remove inline nebulizers from the ventilator circuit and disinfect or rinse nebulizers with sterile water, air drying between treatments.

5.7. Suction Catheters

Use standard precautions, including eye and face protection during aerosol-generating procedures, should be taken with all patient care activities.

- Open suctioning systems require:



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- a. The use of a sterile catheter, sterile disposable gloves, and sterile normal saline if instillation is desirable.
- b. Personal protective equipment when contact with respiratory secretions is anticipated.
2. Closed suctioning systems may offer better control of lung volume and lead to fewer arrhythmias and desaturation episodes at the expense of increased tracheal colonization.
 - a. Use only sterile fluid to remove secretions from the suction catheter.
 - b. Change inline suction catheters no less frequently than every 72 hours.
3. Change the suction collection tubing and canisters between patients.

5.8. Medication (including multi-dose vials (MDVs))

1. Medication intended for internal or external use should be labeled accordingly and stored separately. Refer to **POLICY OF IPC IN PHARMACY.**
2. Date, time, and initial all MDVs once opened or reconstituted.
3. Refrigerate any opened MDV as recommended by the manufacturer.
4. Clean the rubber diaphragm of the MDV with 70% isopropyl alcohol before inserting a device into the vial.
5. Access the MDV with a sterile device each time.
6. Avoid touch contamination of the MDV.
7. MDVs should be accessed with a sterile needle each time, and the needle should be removed upon completion. The needle should not be left as a means of permanent access because it will provide a point of entry for microorganisms.

5.9. Specimen Collection

1. Sputum/tracheal aspiration/bronchoscopy
 - a. The patient should clean his/her teeth, gargle, and rinse his/her mouth with water just prior to collection.
 - b. The best specimen is an early morning collection. Refer to hospital microbiology laboratory policies.
 - c. For tracheal aspiration, follow the nursing procedure guidelines that pertain to patient preparation and specimen collection.
 - d. Wear appropriate PPE (Standard Precautions) during sputum induction.
 - e. Perform sputum inductions in a private room with 6 air exchanges per hour if possible.
 - f. Keep the door closed during the procedure.
 - g. **Ask the patient's visitors to leave the room during sputum induction.**
2. Percutaneous blood gases
 - a. Perform hand hygiene and use gloves.



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- b. Perform adequate skin preparation on the patient with hospital-approved antiseptic.
- c. Use sterile supplies.
- d. Do not precool syringes by submerging them in ice water.
- e. Avoid repeating unsuccessful arterial punctures with the same needle or cannula.
- f. Handle all body fluids as if contaminated.
- g. Dispose and transport specimens as appropriate.

5.10. Respiratory Devices

1. Resuscitation bags
 - a. Sterilization or high-level disinfection of bags between patients is recommended.
 - b. When using a bag on the same patient, rinse it clear with sterile water immediately when the bag valve is visibly soiled with secretions.
 - c. Reusable bags must be sent to CSSD for reprocessing.
2. Oxygen masks and cannulas
 - a. Change tubing and any device, such as a cannula and mask, used to deliver oxygen from a wall outlet between patients.
 - b. Restrict the use of bubble type humidifiers (BTHs) to appropriate situations. Humidifiers are not indicated for oxygen flow less than 4 L/min in adult patients under normal conditions.
 - c. When operated at a flow above 10 L/min, a standard unheated BTH designed for oxygen delivery is less efficient than a humidifier and may create aerosols that can transmit bacteria.
3. Pulse oximetry
 - a. Disinfect probes immediately between patients according to the manufacturer's recommendations.
 - b. Avoid the use of clip-on probes over edematous areas.
 - c. Check the site frequently, repositioning the probe as necessary.
 - d. Reposition all probes at appropriate time intervals in accordance with the manufacturer's recommendations.
4. Pulmonary function testing (PFT)
 - e. Disinfect the surfaces of any device that comes into patient contact after each patient.
 - f. Do not routinely disinfect the internal machinery of PFT machines between uses.
 - g. Sterilize or disinfect any external devices (e.g., nose clips and mouthpieces) between patients according to the manufacturer's recommendations.
 - h. The use of low-resistance, high-efficiency filters has been advocated for use between the mouth-piece and the spirometer to minimize contamination between device and patient. This filter may also reduce



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HCW exposure to droplet nuclei generated by the patient during forced expiratory maneuvers.

5.11. Reprocessing Respiratory Care Services

1. Respiratory care devices have been classified as semi-critical because they come into contact with mucous membranes but do not ordinarily penetrate body surfaces.
2. All single-use disposable devices must be discarded immediately after use.
3. Do not reprocess equipment and devices that are manufactured "for single use only"; refer to Single Use Devices.
4. Proper cleaning and sterilization or high-level disinfection of reusable equipment is important to reduce infection.
5. All reusable equipment or devices must be sent to CSSD for reprocessing.
6. The manufacturer's recommendations must be made available to CSSD to efficiently and effectively clean, disinfect and sterilize these items.

6.0.ATTACHMENT

6.1. N/A

7.0.REFERENCES

- 7.1.The GCC Infection Prevention Control Manual
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8.0.APPROVAL

	NAME	POSITION	SIGNATURE	DATE
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	Ms. Maraim sahli	CSSD supervisor		9-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
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1.0. PURPOSE

- 1.1. To provide clear guidelines on infection control issues for patients, healthcare workers, and equipment to prevent the transmission of infections during the delivery of service.

2.0. DEFINITION

- 2.1. N/A

3.0. RESPONSIBILITY

- 3.1. All Al Harth Rehabilitation Center

4.0.POLICY

- 4.1. The rehabilitation patient may have one or more impairments or disabilities at the time of admission that increase the risk of infection.
- 4.2. Factors such as incontinence, skin breakdown, co-morbidity, immobility, and age are all associated with increased risks of infection in the rehabilitation population.

5.0.PROCEDURE

A. Rehabilitation Standards

1. Treatment may require many different types of equipment to increase movement and mobility, heal wounds, and treat neurological and sensory impairments. Many patients also have secondary medical conditions that can affect the outcome of their rehabilitation.
2. Prevention begins before admission. The infection control needs of the patient must be known (whether for in-patient or out-patient procedures) before he/she is treated. Questions should include the following:
 - a. Does the patient have non-intact skin, open wounds, stasis ulcers, open burn wounds, or indwelling devices?
 - b. Does the patient have loose stools/diarrhea?
 - c. Does the patient have fecal or bladder incontinence?
 - d. Does the patient have any excretions or secretions that cannot be contained?



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- Did the patient have an extended ICU stay or surgery?
 - Is the patient willing or cognitively able to cooperate in strategies to contain his or her own body secretions?
 - Does the patient have an active or colonized infection of multidrug-resistant organisms?
 - Has the patient been intubated? Do they have swallowing strategies or aspiration risks?
3. The rehabilitation department must evaluate the numerous factors that influence transmission risks and their unique settings to develop and implement policies and procedures that apply to the type of patients they treat and the services they provide, thereby, managing and minimizing the risk of infection transmission.

B. Rehabilitation Personnel

Staff should be able to apply the infection control principles and practices described in the Infection Control Manual during patient care activities. Basic infection control practices include the use of **Standard Precautions with all patients receiving care regardless of their diagnosis or presumed infectious status. These practices are important for reducing the risk of disease transmission among patients and HCWs.**

Rehabilitation Services staff are expected to:

- Use Standard Precautions for all patient care. Refer to Standard Precautions.
- Use personal protective equipment (PPE) individually or in combination for any/all procedures that require close contact with the patient and the patient's environment regardless of whether the patient is in isolation.
- Change PPE before providing care to another patient.
- Wash or cleanse hands before and after all contact with the patient and the patient's environment. Refer to Hand Hygiene. Wash and dry or cleanse hands before and after glove use.
- Follow required isolation precautions when entering the rooms of patients in isolation. Refer to Isolation Precautions, protocols through Contact Isolation, Droplet Isolation, and Airborne Isolation Precautions.

C. Disinfection and sterilization protocols for therapy and patient care

Equipment used to provide rehabilitative services to patients may present an increased risk of infection to the patient, other patients, and HCWs. Written



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policies are needed to ensure that equipment is cleaned and disinfected between patients.

1. The department must have written guidelines for:
 - a. Routine cleaning and disinfection of equipment (canes, walkers, wheelchairs, weights, lifts, etc.) and toys following each patient use. Use only hospital-approved disinfectants to wipe down equipment.
 - b. Cleaning and disinfecting equipment after body fluid contamination (including whirlpools and hydrotherapy baths).
 - c. A method for documenting and validating that equipment has been cleaned and disinfected.
2. Some examples of cleaning in the therapy area are:
 - a. Disinfect treatment mats between uses and inspected for any cracks and tears that compromise the integrity of their covers.
 - b. Change paper pillow covers between patients.
 - c. Change daily pillow cases or as needed when body fluids are present (i.e., they are visibly soiled).
 - d. For types of equipment that cannot be cleaned, such as paraffin or therapy putty, instruct patients to wash their hands or feet before use. Cover patients wounds with occlusive dressing or therapy must be delayed until the wounds are healed.
3. The water in hydrotherapy, whirlpools, and aquatic therapy pools can be a source of and vehicle for transmission of infectious organisms. Some patients may have to be excluded from these types of therapies due to open wounds or the inability to contain fecal matter.
 - a. Preventive measures to decrease the risk of microbial contamination of hydrotherapy pools:
 - i. Educate the patients and sitters about basic infection control measures prior to the start of therapy to ensure compliance.
 - i. Ensure pre-swim hygiene such as showering before therapy to remove traces of sweat, urine, fecal matter, cosmetics, oil and other potential contaminants.
 - ii. Do not allow bathers to use the pool if with open infected wounds, severe skin fungal infections, with herpetic lesions, vomiting, diarrhea, conjunctivitis and fecal incontinence.
 - iv. Patients known to be positive for blood-borne pathogens such as Hepatitis B, Hepatitis C and HIV are allowed entry provided



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- if there are no open wounds.
- b. Water testing, frequency of testing and disinfection
 - i. Maintain the proper levels of disinfectant in pools to control organic load.
 - i. Test the level of free available chlorine, pH, total alkalinity and temperature on a daily basis. The results should be recorded and posted in the area. Acceptable chlorine levels are 1.5 to 2.0 ppm with pH ranging from 7.5 to 7.8.
 - ii. Collect microbiological samples before chemical samples to avoid accidental contamination of the pool water with microorganisms and from the sampler.
 - iv. Schedule routine sampling for microbiological testing. Additionally, sampling should also be considered in the following situations: before a pool is use for the first time; before it is put back to use after repairs; if there are problems with the disinfection system and as part of any outbreak investigations (i.e., diarrheal illness).
 - vi. Document outcome of water testing.
 - vii. Clean immersion tanks and whirlpools with the appropriate disinfectant and follow the manufacturer's recommendations.
 - vi. Intermediate level disinfection is required for treatment tanks used with patients with non-intact skin between each patient use.
 - vii. Disinfect equipment with agitator jets with the solution covering the jets and the jets in circulation while disinfecting.
 - viii. Discard single-use disposable patient care items immediately after use and are not to be reprocessed or reused (refer to Single Use Devices).
 - ix. Refer to Sterile Supplies and Equipment Management for most items/equipment in this area are typically non-critical; except, for any semi-critical or critical reusable patient care items which will require reprocessing.
 - c. Recommended microbiological testing of hydrotherapy pool--microorganisms that are used to assess the microbial quality of hydrotherapy pool include:
 - i. HPC (Heterotrophic plate count): a general measure of non-specific microbial levels, which gives a measure of the overall general quality of the pool water, and whether the filtration and



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disinfection systems are operating satisfactorily. Refer to Water Quality Monitoring Program and Requirements.

- i Fecal indicators (such as thermo tolerant coliforms, E. coli) is a normal inhabitant of the intestinal tract of human and is almost exclusively of fecal origin, so its detection in the water samples indicates recent fecal contamination.
- ii Non-fecally derived microorganism (e.g. P. aeruginosa) is an opportunistic pathogen commonly found in water, soil and vegetation, but can also be found in human feces. It can cause diseases like ear and eye infections and folliculate skin infections. Although slightly resistant to a range of disinfectants, chlorination of swimming pools should be sufficient to kill bacterium.

Table 1-VIII-07: Microbiological Parameters

Type of Test	Limit
E. coli	<1 cfu/100 ml. of water sample
Pseudomonas aeroginosa	<1 cfu/100 ml. of water sample

D. Infection Control Issues for the Patient

Basic principles of infection control must be included in the delivery of service for all patients whether in inpatient or outpatient settings:

1. For all patients:
 - a. Standard precautions must be used when providing care.
 - b. All drainages, wounds, and excretions must be contained before a patient can schedule therapies and activities.
 - c. The patient must be able to control secretions or excretions.
 - d. Equipment (rehab or physiotherapy equipment, stretchers, wheelchairs, etc.) must be cleaned and disinfected after each patient use. Only use hospital-approved disinfectants.



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2. For a patient known to be infected or colonized with a multidrug-resistant organism (MDRO) (e.g., MRSA, VRE, or multidrug-resistant gram-negative organisms such as Acinetobacter) in the outpatient setting:
 - a. Use PPE individually or in combination for any/all procedures that require close contact with the patient
 - b. Change PPE before providing care to another patient
 - c. Designate equipment if available and possible
 - d. Schedule patient at the end of the day if therapy equipment cannot be designated.
 - e. Clean and disinfect equipment (rehab or physiotherapy equipment, stretchers, wheelchairs, etc.) after each patient use.
Only use hospital-approved disinfectants
 - f. The patient can participate in group activities only if he/she can:
 - i Understand and follow basic hand hygiene practices.
 - i Assist HCWs in containing his/her secretions and excretions.
 - ii Remain fully dressed.
3. Inpatients on contact isolation precautions:

A patient known to be infected or colonized with a MDRO (e.g., MRSA, VRE, or multidrug resistant gram-negative organisms such as Acinetobacter) will be placed in contact isolation.

Rehabilitation Service staff is expected to:

 - a. Follow the procedure described in Contact Isolation Precautions.
 - b. Observe Standard Precautions when providing care to all patients.
 - c. Consider the following factors when preparing care plans for patients with multidrug-resistant organisms are:
 - i How much care the patient needs.
 - i Anticipation of the amount of contact with body fluids.
 - ii The patient's ability to control secretions or excretions.
 - iv The level of activity and mobility.
 - v Skin integrity and wounds.
 - d. Use barrier protection to contain wounds, drainage, urine, feces, and other excretions or secretions whenever possible to allow for patient independence and participation in therapeutic sessions or if patient has to leave his/her room. For example:
 - i The patient must have occlusive wound dressings, anchored urine bags, etc.
 - i The patient must be able to comply with hand hygiene protocols and stay



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fully dressed.

- e. Use PPE individually or in combination for any/all procedures that require close contact with the patient and the patient's environment. Change PPE before providing care to another patient.

Recommend dedicated equipment. Equipment (rehab or physiotherapy equipment, stretchers, wheelchairs, etc.) taken into the room and used with a patient must be cleaned and disinfected after use. Use only hospital-approved disinfectants to wipe down equipment. Inpatient on airborne isolation precautions:

A patient suspected or confirmed to be infected with an airborne transmissible disease such as pulmonary TB, chickenpox, measles, or viral hemorrhagic fever will be placed in airborne isolation.

- Follow the procedure in **ICM-III-05** Airborne Isolation Precautions.
- Observe Standard Precautions **ICM-III-03** when providing care to all patients.
- Consider the following factors to consider when preparing care plans for patients with airborne transmissible diseases are:
 - How much care the patient needs.
 - The amount of contact with body fluids (respiratory).
 - The patient's ability to control secretions or excretions.
 - The level of activity and mobility.
- Use barrier protections to contain wounds, drainage, urine, feces, and other excretions or secretions whenever possible to allow for patient independence and participation in therapeutic sessions or if patient has to leave his/her room. For example:
 - The patient must have occlusive wound dressings, anchored urine bags, etc.
 - The patient must be able to comply with wearing a surgical mask, practice proper hand hygiene and stay fully dressed.
- Use PPE individually or in combination for any/all procedures that require close contact with the patient and the patient's environment. Wear an N95 mask for patients in airborne isolation. Immunity is the best protection for prevention of chickenpox transmission.
- Change PPE before providing care to another patient.
- Recommend dedicated equipment. Equipment (rehab or physiotherapy



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equipment, stretchers, wheelchairs, etc.) taken into the room and used with the patient must be cleaned and disinfected after each use. Only use hospital-approved disinfectants.

- h. Consider rescheduling therapy sessions at the end of the day or until patient is non-infectious and acceptable. Consult the Infection Preventionist (IP) if needed.

E. Prevention of Infections in Rehabilitation Settings

Factors such as incontinence, skin breakdown, co-morbidity, and age are all associated with increased risk of infection in rehabilitation patients.

Failure to maintain skin integrity may cause increased infection and may extend the length of stay for the patients.

1. Treating burn patients
 - a. Treatment of the wound consists of meticulous cleansing and debridement of dead tissue.
 - b. Apply topical ointments.
 - c. Use sterile technique and sterile dressings to control wound sepsis.
 - d. Use showers with hand-held spray for hydrotherapy. Use of a hydrotherapy tub or bath is discouraged due to the potential for contamination of the equipment and water.
2. Bladder and bowel issues
 - a. Care of patients who are unable to control their bladder or bowel has to be a priority.
 - b. Keeping the patient's skin clean and dry is essential for good skin care.
 - i. Good perineal care.
 - ii. Intermittent catheterization may be used (example for neurogenic bladder).
 - c. Recommendation for urinary tract infection prevention:
 - i. Follow the established guidelines for catheter use, insertion, and maintenance.
 - ii. Maintain asepsis for urinary catheter insertion.
 - iii. Maintain a sterile, closed drainage system and do not disconnect the catheter and drainage tube unless necessary.
 - iv. Utilize a condom catheter or in-and-out catheters when appropriate.
 - v. Keep the collection bag below the level of the bladder.



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- vi Provide good catheter care on a regular basis.

F. Spill Management

The steps described below should be taken when cleaning and decontaminating spills of blood or other potentially infectious materials; refer to *Management of Infectious Waste*.

When an infectious/medical waste spill has been identified, perform the following steps:

1. Control access to the area.
2. Contain the spill with paper towels or other absorbent materials.
3. Contact housekeeping to disinfect the area.

6.0. ATTACHMENT

6.1. Table 1-VIII-07: Microbiological Parameters

7.0. REFERENCES

7.1. GCC Infection Prevention and Control 3rd Edition Manual (2018)



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8.0. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Ms. Wejdan Bajwi	Rehabilitation director		7-7-2021
	Mr. Hadi Awaji	EH supervisor		2-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms . Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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1.0. PURPOSE:

1.1. To ensure that infection control risk assessment, interventions, and control practices are incorporated into the planning, construction, and renovation in the healthcare setting, by defining the steps and precautions compliant to Infection Prevention & Control procedures to eliminate infection hazards that pose danger to personnel and patients of all healthcare setting.

2.0. DEFINITION:

2.1. N/A

3.0. POLICY:

- 3.1. Applies to all construction/renovation works within and outside any hospital or healthcare facilities, which include preventive maintenance on heating, ventilation and air conditioning (HVAC) system, ventilator cleaning, filter replacement, etc. that may compromise and/or contaminate air and water supply.
- 3.2. Healthcare associated infections are caused by pathogens like Mycobacterium tuberculosis, Aspergillus species, Legionella species present in the dust and debris generated by construction activities. These are considered as major hazards.
- 3.3. The Infection Prevention and Control Department will be involved and pre-informed of all current and future construction activities at the Healthcare facilities. Infection Prevention and Control personnel will be active team members in all phases of any construction/renovation projects where they will play a major role in providing education to workers and staff involved in the project to ensure that preventive measures are outlined, implemented, and maintained.
- 3.4. An established multidisciplinary team composed of Infection Control, Environmental Risk assessment, Safety and Engineering, is responsible in planning, implementing preventive measures for the duration of the construction project and in establishing clear lines of communication among all concerned to ensure patient safety.



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4.0. RESPONSIBILITY:

- 4.1. The Infection Prevention and Control (IP&C) Department will be involved and preinformed of all current and future construction activities in any healthcare facilities. IP&C personnel will be active team members in all phases of any construction / renovation projects where they will play a major role in providing education to workers and staff involved in the project to ensure that preventive measures are outlined, implemented, and maintained.
- 4.2. The Project Management Department will establish a multidisciplinary team primarily composed of the IP&C Environmental Health Specialists and the Engineering Department to coordinate demolition, construction, and renovation projects and to consider proactive preventive measures at the project inception.
- 4.3. The established multidisciplinary team is responsible for planning and implementing preventive measures for the duration of the construction project and for establishing clear lines of communication among all concerned parties to ensure patient safety.
- 4.4. The IP&C Environmental Health and Occupational Health and Safety (EHOHS) section has the authority to stop construction projects if prevention measures were breached that may expose patients and personnel to infection and environmental hazards.

5.0. PROCEDURE:

5.1. Pre-Construction Preventive Measures

- 5.1.1. The multidisciplinary team should include representatives from all concerned departments. All parties must agree on the multidisciplinary action plan.
- 5.1.2. Seasonal effects related to infections should be considered in the work plan for projects.
- 5.1.3. An *Infection Control Risk Assessment Form: Construction Permit* must be filled and signed before starting any construction project.
- 5.1.4. IP&C should be consulted to provide information on the following Infection and Environmental Control Risk Assessment, Matrix of Precautions for Construction and Renovation.



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5.1.4.1. Infection Control Practitioner or Environmental Health Specialist will identify the type of construction project activity using **Appendix Determining the Type of Construction / Renovation**.

5.1.4.2. Using **Appendix (Determining the Patient Risk groups that will be Affected by the Construction / Renovation)** the Infection Control Practitioner will identify the Patient Risk Groups that will be affected.

5.1.4.2. The Infection Control Practitioner or Environmental Health Specialist will match the Patient Risk Group with the Construction Project Type on the following matrix, to find the Class of Precautions or level of Infection and Environmental Control activities required (**Appendix Description of the Required Precautions by Class**).

5.1.5. IP&C approval will be required when the Construction Activity and Risk Level indicate that Class III or Class IV control procedures are necessary.

5.1.6. The Infection Control Practitioner is responsible for:

5.1.6.1. Identifying all the areas surrounding the project and assess the potential hazards.

5.1.6.2. Identifying the specific site of activity e.g., patient rooms, medication room, etc.

5.1.6.3. Assessing whether the plans allow for:

5.1.6.3.1. An adequate number of isolation / negative airflow rooms

5.1.6.3.2. The required number and type of hand washing sinks

5.1.6.4. Assessing whether the minimum number of sinks for the project is available based on the AIA Guidelines for types and area.

5.1.6.5. Assessing whether the plans relative to clean and soiled utility rooms are compliant.

5.1.7. The Environmental Health Specialist is responsible for:

5.1.7.1. Identifying issues related to ventilation, plumbing, and electrical viz. the probable occurrence of outages.

5.1.7.2. Identifying containment measures using prior assessment such as, types of barriers (solid wall) and the need for Hepa filtration.

Note: The renovation / construction area must be isolated from the occupied areas during construction and will be negative with respect to surrounding areas.



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5.1.7.3. Assessing potential risk of water damage and risks due to compromising structural integrity e.g., wall, ceiling, roof.

5.1.7.4. Deciding work hours for the project and assessing whether the work can be done during non-patient care hours.

5.1.7.5. Planning to discuss the containment issues with the project team, e.g., traffic flow, housekeeping, debris removal (how and when).

5.1.8. All contracted construction workers must be aware of the health and safety risks to staff and patients during construction / renovation activities. It is the responsibility of the construction team to comply with the provisions of this policy as outlined by the IP&C department.

5.1.9. The responsible engineering party will:

5.1.9.1. Establish traffic patterns for construction workers that will avoid patient care areas.

5.1.9.2 If possible, designate an elevator to be used solely by the construction workers and ensure that the ventilation of the elevator cab and shaft is not re-circulated in the hospital.

5.1.9.3. Establish a mechanism to ensure timely correction of problems.

5.2. During Construction Preventive Measures

5.2.1. The ward is responsible for addressing the needs of immunocompromised patients. They should be moved to an area away from the construction zone if the air quality cannot be assured during construction. These patients should wear a mask if it is necessary to transport them through or near the construction area.

5.2.2. The responsible engineering party must ensure that:

5.2.2.1. All windows, doors, air intake and exhaust vents are sealed in areas of the hospital adjacent to buildings that are going to be demolished including areas housing patients who are susceptible, to prevent air leaks into patient care areas.

5.2.2.2. A dust barrier is created from the floor to the ceiling with the edges sealed. Plastic (for short-term projects) or sheetrock (for long-term projects) are examples of materials that can be used to seal the construction area.

5.2.2.3. All windows, doors, vents, plumbing penetrations, electrical outlets and any other sources of potential air leak are sealed in the construction zone. Seal all holes, pipes, conduits and punctures appropriately.



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- 5.2.2.4. Air pressure within the construction zone is negative compared with adjacent areas. A fan may be used for this purpose with a HEPA filtered exhaust.
- 5.2.2.5. Air in the construction zone is exhausted directly outside. If this is not possible, then the air should be filtered through a HEPA filter before being re-circulated in the hospital. The integrity of the HEPA filter should be assessed to ensure that it is not punctured or blocked.
- 5.2.2.6. Open ends of exhaust vents are capped to prevent air exhausted from the construction zone, from being drawn into the facility's air supply.
- 5.2.2.7. Air ducts and spaces above ceiling are vacuumed before the construction project is started in the involved areas and repeated before utilization of the area to ensure sufficient functioning. The mechanical or electrical fixtures must be cleaned before installation of ceiling tiles.
- 5.2.2.8. Work surfaces are water misted to control dust while cutting concrete wall or floor.
- 5.2.2.9. A moist carpet to trap dust is placed inside the anteroom and inside the entrance and exit of the construction zone. The carpet should be vacuumed daily or when visibly soiled.
- 5.2.2.10. A mat with a sticky surface is placed directly outside the impermeable barrier (anteroom), to trap dust from the equipment and shoes of personnel leaving the construction zone. Change mat on daily basis.
- 5.2.2.11. The construction zone is cleaned daily using a wet mop technique. Used supplies and equipment are enclosed in covered containers when being transported out of the area to prevent spillage.
- 5.2.2.12. Debris is removed by the construction workers at a period of low activity in the hospital i.e., in the evening when patients are in their rooms and visitors have left. If this is not possible, debris should be removed at the end of the workday by construction workers. Debris should be in tightly covered containers / carts or covered with moistened sheets before it is removed from the construction area. An external chute is used if necessary for removal of debris if construction is not taking place on ground level.
- 5.2.2.13. Faucet aerators and other obstructing and stagnating features (e.g. long pipes and plumbing dead-ends) are removed if possible.
- 5.2.2.14. Dust suppression is maintained in outdoor construction sites.



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5.2.2.15. Copper-8-quinolinolate formulation is considered for application to walls, doors, frames, baseboards, exterior surfaces of radiators, vents in the rooms in the construction area and above false ceilings in adjacent areas.

5.2.2.16. Installation of cleaned ceiling tiles is secured with silicone sealant.

5.2.2.17. The partition floor track is clean prior to installation of sound insulation and closing of partition.

5.2.3. All departments are responsible for reporting any discoloration of water promptly to maintenance and infection control personnel. Alternate water sources should be considered for patient use.

5.2.4. Construction workers should wear protective clothing when working in the construction zone because of the high concentration of dust. To limit dust dispersion, if there is no external non-patient area exit, construction workers must remove the protective clothing and vacuum to remove the dust from their clothing before leaving the construction zone.

The supplier of the HEPA filtered vacuum should indicate this provision in the contract document or they can wear clothes or paper coveralls that are removed each time they leave the work site.

5.2.5. All personnel entering work site are required to wear shoe covers. Shoe covers must be removed each time the worker exits the work area.

5.2.6. Infection Control Practitioner / Environmental Health Specialist personnel should regularly (weekly) visit the construction site until the project is completed to ensure that preventive measures are being adhered to or that appropriate modifications are made if there is any onsite design changes. If any concerns are identified, they should be brought to the attention of the responsible Engineering party and to the Infection Prevention & Control Director.

5.2.7. Housekeeping are responsible for ensuring that adjacent areas are vacuumed daily or more frequently if needed with HEPA filtered vacuums.

5.2.8. Engineering in coordination with IP& C-EHOHS are responsible for ensuring adequate signage.

5.3. Post Construction Preventive Measures

5.3.1. The responsible Engineering party should:

5.3.1.1. Thoroughly clean the construction zone, including all horizontal surfaces, before the barrier is removed, and again after the barrier is removed



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and before patients are readmitted to the area. Allow time for all dust to settle before doing final cleaning.

5.3.1.2. Ensure that the multidisciplinary team or designate conducts a final walk through to ensure ventilation system is functioning properly in construction zone and adjacent areas.

5.3.1.3. Flush water lines prior to use if they were disrupted.

5.3.1.4. If there are concerns about *Legionella* and *Aspergillus*, consider hyper-chlorinating stagnant potable water or superheating and flushing all distal sites before restoring or repressurizing the water system.

5.3.1.5. Disinfect unused cooling towers and water supply in unoccupied portions of buildings before they are put in use.

5.3.1.6. Assess hot water temperature to determine that it meets the standards set by the hospital.

5.3.1.7. Ensure that the multidisciplinary team or designate evaluates the preventive measures and reviews their effectiveness for any problems to ensure a positive outcome.

5.3.1.8. Balance the air.

5.3.2. Infection and Environmental control personnel should check the area before patients are readmitted to the finished area and before removing or allowing the removal of the barrier. A fungal air sample will be taken if required.

5.3.3. Housekeeping should clean the area thoroughly including vacuuming the work area with HEPA filtered vacuums.

6.0. MATERIAL/EQUIPMENT:

6.1. N/A

7.0. REFERENCE:

7.1. GCC Manual for Infection Control 3rd Edition Manual(2018)



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8.0.APPROVALS :

	NAME	POSITION	SIGNATURE	DATE
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	Mr. mansor rajhi	FMS Director		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harhi	Hospital Director		26-7-2021



**Appendix IPC41-01-class III/IV
Infection Control Risk Assessment Permit Form - Construction Permit**

نموذج تصريح تقييم مخاطر التحكم في العدوى - رخصة البناء

Type of Construction نوع العمل		Project Start Date تاريخ بداية المشروع	
Construction Location موقع المشروع		Estimated Duration مدة المشروع	
Project Coordinator مسئول المشروع		Mobile الجوال	
Contractor Performing Work المقاول المنفذ		Permit Expiration Date تاريخ انتهاء المشروع	

IC Matrix - Class of Precautions: Construction Project by Patient Risk				
CONSTRUCTION ACTIVITY	Low Risk	Medium Risk	High Risk	Highest Risk
Type A: Inspection, non-invasive activity	I	I	I	I
Type B: Small scale, short duration moderate to high level of dust.	II	II	II	III / IV
Type C: Activity generates moderate to high levels of dust and/ or noise.	II	III	III / IV	III / IV
Type D: Major duration and construction activities requiring consecutive work shifts	III / IV	IV	IV	IV

IV إجراءات الاحتياطية التصنيف IV CLASS IV Precautions	
1 Obtain Infection Control permit before construction begins.	الحصول على تصريح مكافحة العدوى قبل البدء في البناء
2 Isolate HVAC system in area where work is being done to prevent contamination of the duct system	إيقاف التكيف بالوحدة أثناء العمل
3 Complete all critical barriers such as sheetrock, plywood, plastic to seal area from non-work area or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit) before construction begins.	تنفيذ جميع الحواجز الهامة قبل البدء بالعمل بالمشروع مثل الألواح الخشبية، الجبس بورد، والبلاستيك لأقفال المنطقة عن منطقة غير العمل أو تنفيذ طريقة مكعب التحكم (عربة ذات غطاء بلاستيكي محكم الإغلاق إلى موقع العمل مع مكينة HEPA للتنظيف قبل الخروج) قبل بدء عملية الترميم.
4 Maintain negative air pressure within work site.	الحفاظ على ضغط الهواء السلبي داخل موقع العمل.
5 Seal holes, pipes, conduits, and punctures appropriately.	سد الثقوب والأنابيب والمواسير بشكل جيد.
6 Construction anteroom and require all personnel to pass through this room so they can be vacuumed using a HEPA vacuum cleaner before leaving work site or they can wear cloth or paper coveralls that are removed each time they leave the work site.	إنشاء غرفة قبل الدخول للمشروع ويطلب من جميع الموظفين المرور عبرها حتى يمكن التنظيف باستخدام مكينة كهربية HEPA قبل مغادرة موقع العمل أو يمكنهم ارتداء قممات أو معاطف الورق التي يتم إزالتها في كل مرة يغادرون موقع العمل.
All personnel entering work site are required to wear shoe covers.	جميع الموظفين الداخلين إلى موقع العمل ملزمون بارتداء أغطية للقدم.
8 Do not remove barriers from work area until completed project is thoroughly cleaned by the Environmental Services Department.	يمنع إزالة الحواجز من منطقة العمل حتى اكتمالها وتنظيفها من قبل صحة البيئة.
9 Provide Safety Data Sheet (SDS) for paint and disinfectants prior to use.	توفير ورقة بيانات السلامة للطلاء والمطهرات قبل الاستخدام.

Upon completion of project عند الانتهاء من المشروع	
1 Do not remove barriers from work area until project is inspected by IP&C as well as, thoroughly cleaned by the construction workers and the Environmental Services department.	يمنع إزالة الحواجز من منطقة العمل حتى يتم فحص المشروع من قبل قسم مكافحة العدوى، بالإضافة إلى تنظيفها بالكامل من قبل عمال البناء وإدارة الخدمات البيئية.
2 Remove barrier materials carefully to minimize spread of dirt and debris as a result of construction activities.	إزالة المواد الحاجزة بعناية للحد من انتشار الأوساخ والحطام نتيجة لأنشطة البناء.
3 Contain construction waste before transport in tightly covered containers.	تجميع مخلفات البناء قبل النقل في حاويات مغطاة بإحكام.
4 Cover transport receptacles or carts. Tape covering unless solid lid.	تغطية عربات النقل بغطاء كالبلاستيك أو شريط إذا لم يتوفر غطاء قوي.
5 Vacuum work with HEPA filtered vacuums.	استخدام مضخة السحب مرتبطة بفلتر HEPA
6 Use wet mop with disinfectant.	استخدام المطهرات للأسطح
7 Remove isolation of HVAC system in areas where work has been performed.	إعادة التكيف في المناطق التي تم فيها تنفيذ العمل.

Recommended by: التوصيات من قبل	
Facility Management مدير الصيانة	مكتب المشاريع
Permit Requested by المتقدم لتنفيذ المشروع	Signature & Date: التوقيع والتاريخ
Approved by: Infection Prevention & Control اعتماد التوصيات من قبل مكافحة العدوى	
Name	Signature & Date

Appendix IPC41-01-class IV
Infection Control Risk Assessment Permit Form - Construction Permit

نموذج تصريح تقييم مخاطر التحكم في العدوى - رخصة البناء

Type of Construction نوع العمل		Project Start Date تاريخ بداية المشروع	
Construction Location موقع المشروع		Estimated Duration مدة المشروع	
Project Coordinator مسئول المشروع		Tel. Ext. تلفون	
Contractor Performing Work المقاول المنفذ		Permit Expiration Date تاريخ انتهاء المشروع	
Supervisor مشرف المشروع		Mobile الجوال	

IC Matrix - Class of Precautions: Construction Project by Patient Risk

CONSTRUCTION ACTIVITY	Low Risk	Medium Risk	High Risk	Highest Risk
Type A: Inspection, non-invasive activity	I	I	I	I
Type B: Small scale, short duration moderate to high level of dust.	II	II	II	III / IV
Type C: Activity generates moderate to high levels of dust and/ or noise.	II	III	III / IV	III / IV
Type D: Major duration and construction activities requiring consecutive work shifts	III / IV	IV	IV	IV

CLASS IV Precautions

IV	التدابير الاحتياطية والتصنيف	الحصول على تصريح مكافحة العدوى قبل البدء في البناء
1	Obtain Infection Control permit before construction begins.	الحصول على تصريح مكافحة العدوى قبل البدء في البناء
2	Isolate HVAC system in area where work is being done to prevent contamination of the duct system	إيقاف التدفئة بالوحدة أثناء العمل
3	Complete all critical barriers such as sheetrock, plywood, plastic to seal area from non-work area or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit) before construction begins.	تنفيذ جميع الحواجز الهامة قبل البدء بالعمل بالمشروع مثل الألواح الخشبية، الجبس بورد، والبلاستيك لأقفال المنطقة عن منطقة غير العمل أو تنفيذ طريقة مكعب التحكم (عربة ذات غطاء بلاستيكي محكم الإغلاق إلى موقع العمل مع مكينة HEPA للتنظيف قبل الخروج) قبل بدء عملية الترميم.
4	Maintain negative air pressure within work site.	الحفاظ على ضغط الهواء السلبي داخل موقع العمل.
5	Seal holes, pipes, conduits, and punctures appropriately.	سد الثقوب والأنابيب والمواسير بشكل جيد.
6	Construction anteroom and require all personnel to pass through this room so they can be vacuumed using a HEPA vacuum cleaner before leaving work site or they can wear cloth or paper coveralls that are removed each time they leave the work site.	إنشاء غرفة قبل الدخول للمشروع ويطلب من جميع الموظفين المرور عبرها حتى يمكن التنظيف باستخدام مكينة كهربية HEPA قبل مغادرة موقع العمل أو يمكنهم ارتداء قممات أو معاطف الورق التي يتم إزالتها في كل مرة يغادرون موقع العمل.
7	All personnel entering work site are required to wear shoe covers.	جميع الموظفين الداخلين إلى موقع العمل ملزمون بارتداء أغطية للأقدام.
8	Do not remove barriers from work area until completed project is thoroughly cleaned by the Environmental Services Department.	يمنع إزالة الحواجز من منطقة العمل حتى اكتمالها وتنظيفها من قبل صحة البيئة.
9	Provide Safety Data Sheet (SDS) for paint and disinfectants prior to use.	توفير ورقة بيانات السلامة للطلاء والمطهرات قبل الاستخدام.

Upon completion of project

عند الانتهاء من المشروع	التوصيات من قبل
1 Remove barrier materials carefully to minimize spread of dirt and debris as a result of construction activities.	إزالة المواد الحاجزة بعناية للحد من انتشار الأوساخ والحطام نتيجة لأنشطة البناء.
2 Contain construction waste before transport in tightly covered containers.	تجميع مخلفات البناء قبل النقل في حاويات مغطاة بإحكام.
3 Cover transport receptacles or carts. Tape covering unless solid lid.	تغطية عربات النقل بغطاء كالبلاستيك أو شريط إذا لم يتوفر غطاء قوي.
4 Vacuum work with HEPA filtered vacuums.	استخدام مضخة السحب مرتبطة بفلتر HEPA
5 Use wet mop with disinfectant.	استخدام المطهرات للأسطح
Remove isolation of HVAC system in areas where work has been performed.	إعادة التدفئة في المناطق التي تم فيها تنفيذ العمل.

Recommended by:

Facility Management مدير الصيانة	Project Management Office مكتب المشاريع
Permit Requested by	Signature & Date:

رقم التصريح /
تاريخ التصريح /



مستشفى الحريث العام
مكتب المشاريع وتصريح العمل

المتقدم لتنفيذ المشروع	التوقيع والتاريخ	
Approved by: Infection Prevention & Control		اعتماد التوصيات من قبل مكافحة العدوى
Name	Signature & Date	

Appendix IPC41-01-class III
Infection Control Risk Assessment Permit Form - Construction Permit
نموذج تصريح تقييم مخاطر التحكم في العدوى - رخصة البناء

Type of Construction نوع العمل		Project Start Date تاريخ بداية المشروع	
Construction Location موقع المشروع		Estimated Duration مدة المشروع	
Project Coordinator مسئول المشروع		Tel. Ext. تلفون	
Contractor Performing Work المقاول المنفذ		Permit Expiration Date تاريخ انتهاء المشروع	
Supervisor مشرف المشروع		Mobile الجوال	

IC Matrix - Class of Precautions: Construction Project by Patient Risk

CONSTRUCTION ACTIVITY	Low Risk	Medium Risk	High Risk	Highest Risk
Type A: Inspection, non-invasive activity	I	I	I	I
Type B: Small scale, short duration moderate to high level of dust.	II	II	II	III / IV
Type C: Activity generates moderate to high levels of dust and/ or noise.	II	III	III / IV	III / IV
Type D: Major duration and construction activities requiring consecutive work shifts	III / IV	IV	IV	IV

CLASS III Precautions إجراءات الاحتياطية التصنيف III

1	Obtain Infection Control permit before construction begins.	الحصول على تصريح مكافحة العدوى قبل البدء في البناء
2	Remove or Isolate HVAC system in area where work is being done to prevent contamination of the duct system	إيقاف التكيف بالوحدة أثناء العمل
3	Complete all critical barriers such as sheetrock, plywood, plastic to seal area from non-work area or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit) before construction begins.	تنفيذ جميع الحواجز الهامة قبل البدء بالعمل مثل الألواح الخشبية، الجبس بورد، والبلاستيك لأقفال المنطقة عن منطقة غير العمل أو تنفيذ طريقة مكعب التحكم (عربة ذات غطاء بلاستيكي محكم الإغلاق إلى موقع العمل مع مكنسة HEPA للتنظيف قبل الخروج) قبل بدء عملية الترميم.
4	Maintain negative air pressure within work site.	الحفاظ على ضغط الهواء السلبي داخل موقع العمل.
5	Contain construction waste before transport in tightly covered containers. Choose low traffic and route.	وضع دعسات (حصيرة) للحد من الاتربة للمداخل والمخارج
6	Cover transport receptacles or carts. Tape covering unless solid lid.	تغطية عربات النقل بغطاء كالبلاستيك أو شريط اذا لم يتوفر غطاء قوي.
7	Provide Safety Data Sheet (SDS) for paint and disinfectants prior to use.	توفير ورقة بيانات السلامة للطلاء والمطهرات قبل الاستخدام.

Upon completion of project عند الانتهاء من المشروع

1	Do not remove barriers from work area until project is inspected by IP&C as well as, thoroughly cleaned by the construction workers and the Environmental Services department.	يمنع إزالة الحواجز من منطقة العمل حتى يتم فحص المشروع من قبل قسم مكافحة العدوى، بالإضافة إلى تنظيفها بالكامل من قبل عمال البناء وإدارة الخدمات البيئية.
2	Remove barrier materials carefully to minimize spreading of dirt and debris associated with construction.	إزالة الحاجز بعناية للحد من انتشار الأوساخ والحطام المرتبطة بالبناء
3	Vacuum work with HEPA filtered vacuums.	استخدام مضخة السحب مرتبطة بفلتر HEPA
4	Wet mop with disinfectant.	استخدام المطهرات للأسطح
5	Remove isolate HVAC system in areas where work is being performed.	إعادة التكيف في المناطق التي تم فيها تنفيذ العمل.

Recommended by: التوصيات من قبل

Facility Management مدير الصيانة		Project Management Office مكتب المشاريع	
Permit Requested by المتقدم لتنفيذ المشروع		Signature & Date: التوقيع والتاريخ	

Approved by: Infection Prevention & Control

اعتماد التوصيات من قبل مكافحة العدوى

Name		Signature & Date	
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Appendix IPC41-01-class III/IV
Infection Control Risk Assessment Permit Form - Construction Permit

نموذج تصريح تقييم مخاطر التحكم في العدوى - رخصة البناء

Type of Construction نوع العمل		Project Start Date تاريخ بداية المشروع	
Construction Location موقع المشروع		Estimated Duration مدة المشروع	
Project Coordinator مسئول المشروع		Mobile الجوال	
Contractor Performing Work المقاول المنفذ		Permit Expiration Date تاريخ انتهاء المشروع	

IC Matrix - Class of Precautions: Construction Project by Patient Risk

CONSTRUCTION ACTIVITY	Low Risk	Medium Risk	High Risk	Highest Risk
Type A: Inspection, non-invasive activity	I	I	I	I
Type B: Small scale, short duration moderate to high level of dust.	II	II	II	III / IV
Type C: Activity generates moderate to high levels of dust and/ or noise.	II	III	III / IV	III / IV
Type D: Major duration and construction activities requiring consecutive work shifts	III / IV	IV	IV	IV

IV التصنيف الاحتياطية الإجراءات CLASS IV Precautions

1	Obtain Infection Control permit before construction begins.	الحصول على تصريح مكافحة العدوى قبل البدء في البناء
2	Isolate HVAC system in area where work is being done to prevent contamination of the duct system	إيقاف التكيف بالوحدة أثناء العمل
3	Complete all critical barriers such as sheetrock, plywood, plastic to seal area from non-work area or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit) before construction begins.	تنفيذ جميع الحواجز الهامة قبل البدء بالمشروع مثل الألواح الخشبية، الجبس بورد، والبلاستيك لأقفال المنطقة عن منطقة غير العمل أو تنفيذ طريقة مكعب التحكم (عربة ذات غطاء بلاستيكي محكم الإغلاق إلى موقع العمل مع مكينة HEPA للتنظيف قبل الخروج) قبل بدء عملية الترميم.
4	Maintain negative air pressure within work site.	الحفاظ على ضغط الهواء السلبي داخل موقع العمل.
5	Seal holes, pipes, conduits, and punctures appropriately.	سد الثقوب والأنابيب والمواسير بشكل جيد.
6	Construction anteroom and require all personnel to pass through this room so they can be vacuumed using a HEPA vacuum cleaner before leaving work site or they can wear cloth or paper coveralls that are removed each time they leave the work site.	إنشاء غرفة قبل الدخول للمشروع ويطلب من جميع الموظفين المرور عبرها حتى يمكن التنظيف باستخدام مكينة كهربائية HEPA قبل مغادرة موقع العمل أو يمكنهم ارتداء قماش أو معاطف الورق التي يتم إزالتها في كل مرة يغادرون موقع العمل.
7	All personnel entering work site are required to wear shoe covers.	جميع الموظفين الداخلين إلى موقع العمل ملزمون بارتداء أغطية للقدم.
8	Do not remove barriers from work area until completed project is thoroughly cleaned by the Environmental Services Department.	يمنع إزالة الحواجز من منطقة العمل حتى اكتمالها وتنظيفها من قبل صحة البيئة.
9	Provide Safety Data Sheet (SDS) for paint and disinfectants prior to use.	توفير ورقة بيانات السلامة للطلاء والمطهرات قبل الاستخدام.

عند الانتهاء من المشروع Upon completion of project

1	Do not remove barriers from work area until project is inspected by IP&C as well as, thoroughly cleaned by the construction workers and the Environmental Services department.	يمنع إزالة الحواجز من منطقة العمل حتى يتم فحص المشروع من قبل قسم مكافحة العدوى، بالإضافة إلى تنظيفها بالكامل من قبل عمال البناء وإدارة الخدمات البيئية.
2	Remove barrier materials carefully to minimize spread of dirt and debris as a result of construction activities.	إزالة المواد الحاجزة بعناية للحد من انتشار الأوساخ والحطام نتيجة لأنشطة البناء.
3	Contain construction waste before transport in tightly covered containers.	تجميع مخلفات البناء قبل النقل في حاويات مغطاة بإحكام.
4	Cover transport receptacles or carts. Tape covering unless solid lid.	تغطية عربات النقل بغطاء كالبلاستيك أو شريط إذا لم يتوفر غطاء قوي.
5	Vacuum work with HEPA filtered vacuums.	استخدام مضخة السحب مرتبطة بفلتر HEPA
6	Use wet mop with disinfectant.	استخدام المطهرات للأسطح
7	Remove isolation of HVAC system in areas where work has been performed.	إعادة التكيف في المناطق التي تم فيها تنفيذ العمل.

Recommended by: التوصيات من قبل

Facility Management مدير الصيانة		مكتب المشاريع	
Permit Requested by		Signature & Date:	

المتقدم لتنفيذ المشروع	التوقيع والتاريخ
Approved by: Infection Prevention & Control	
اعتماد التوصيات من قبل مكافحة العدوى	
Name	Signature & Date

Appendix IPC41-01-class I
Infection Control Risk Assessment Permit Form - Construction Permit
نموذج تصريح تقييم مخاطر التحكم في العدوى - رخصة البناء

Type of Construction نوع العمل		Project Start Date تاريخ بداية المشروع	
Construction Location موقع المشروع		Estimated Duration مدة المشروع	
Project Coordinator مسئول المشروع		Tel. Ext. تلفون	
Contractor Performing Work المقاول المنفذ		Permit Expiration Date تاريخ انتهاء المشروع	
Supervisor مشرف المشروع		Mobile الجوال	

IC Matrix - Class of Precautions: Construction Project by Patient Risk				
CONSTRUCTION ACTIVITY	Low Risk	Medium Risk	High Risk	Highest Risk
Type A: Inspection, non-invasive activity	I	I	I	I
Type B: Small scale, short duration moderate to high level of dust.	II	II	II	III / IV
Type C: Activity generates moderate to high levels of dust and/ or noise.	II	III	III / IV	III / IV
Type D: Major duration and construction activities requiring consecutive work shifts	III / IV	IV	IV	IV

I إجراءات الاحتياطية التصنيف CLASS I Precautions	
1 Implement work methods to minimize dust dispersion from construction operations.	تنفيذ جميع الاحتياطات للحد من الغبار أثناء عمليات البناء.
2 Immediate replace any ceiling tile displaced for visual inspection.	استبدال فوري لبلاط السقف المفقود أثناء للتفتيش البصري.
3 Minor demolition for remodeling.	إعادة التهيئة أثناء الترميم البسيط
4 Provide Safety Data Sheet (SDS) for paint and disinfectants prior to use.	توفير ورقة بيانات السلامة (SDS) للطلاء والمطهرات قبل الاستخدام.

Upon completion of project عند الانتهاء من المشروع	
1 Clean work area upon completion of task.	تنظيف منطقة العمل عند الانتهاء من المهمة.

Recommended by: التوصيات من قبل	
Facility Management مدير الصيانة	Project Management Office مكتب المشاريع
Permit Requested by المتقدم لتنفيذ المشروع	Signature & Date: التوقيع والتاريخ
Approved by: Infection Prevention & Control اعتماد التوصيات من قبل مكافحة العدوى	
Name	Signature & Date

Appendix IPC41-01-class II
Infection Control Risk Assessment Permit Form - Construction Permit
نموذج تصريح تقييم مخاطر التحكم في العدوى - رخصة البناء

Type of Construction نوع العمل		Project Start Date تاريخ بداية المشروع	
Construction Location موقع المشروع		Estimated Duration مدة المشروع	
Project Coordinator مسئول المشروع		Tel. Ext. تلفون	
Contractor Performing Work المقاول المنفذ		Permit Expiration Date تاريخ انتهاء المشروع	
Supervisor مشرف المشروع		Mobile الجوال	

IC Matrix - Class of Precautions: Construction Project by Patient Risk				
CONSTRUCTION ACTIVITY	Low Risk	Medium Risk	High Risk	Highest Risk
Type A: Inspection, non-invasive activity	I	I	I	I
Type B: Small scale, short duration moderate to high level of dust.	II	II	II	III / IV
Type C: Activity generates moderate to high levels of dust and/ or noise.	II	III	III / IV	III / IV
Type D: Major duration and construction activities requiring consecutive work shifts	III / IV	IV	IV	IV

II تصنيف II CLASS II Precautions		إجراءات الاحتياطية
1	Provide active means to prevent air-borne dust from dispersing into atmosphere.	توفير وسائل فعالة لمنع الغبار.
2	Water mist work surfaces to control dust while cutting.	الترطيب بالماء للتحكم في الغبار في حين التكسير.
3	Seal unused doors with duct tape	أغلق الأبواب غير المستخدمة بشريط لاصق
4	Block off and seal air vents.	قم بفصل فتحات الهواء واغلاقها.
5	Place dust mat at entrance and exit of work area	وضع دعسات (حصيرة) للحد من الاتربة للمداخل والمخارج
6	Remove or isolate HVAC system in areas where work is being performed.	إيقاف التكيف بالوحدة أثناء العمل
7	Provide Safety Data Sheet (SDS) for paint and disinfectants prior to use.	توفير ورقة بيانات السلامة للطلاء والمطهرات قبل الاستخدام.

Upon completion of project		عند الانتهاء من المشروع
1	Wipe work surfaces with hospital approved disinfectant.	مسح الأسطح بالمطهرات المستخدمة بالمستشفى
2	Contain construction waste before transport in tightly covered containers.	وضع المخلفات في حاوية مغطاة بأحكام
3	Choose low traffic and route.	اختيار ممر قليل الاستخدام
4	Wet mop and / or vacuum with HEPA filtered vacuum before leaving work area.	استخدم الممسحة الرطبة أو جهاز HEPA فيل مغادرة الموقع
5	Remove isolate HVAC system in areas where work is being performed.	إعادة التكيف بالوحدة بعد الانتهاء من العمل

Recommended by:		التوصيات من قبل	
Facility Management مدير الصيانة		Project Management Office مكتب المشاريع	
Permit Requested by المتقدم لتنفيذ المشروع		Signature & Date: التوقيع والتاريخ	
Approved by: Infection Prevention & Control		اعتماد التوصيات من قبل مكافحة العدوى	
Name		Signature & Date	

Appendix 02-A Determining The Type Of Construction / Renovation

نموذج تحديد نوع الترميم / البناء

Type A النوع الاول Inspection and non-invasive activities including, but not limited to: التفتيش والأنشطة غير اجرائية بما في ذلك على سبيل المثال.	1- Removal of ceiling tiles for visual inspection limited to tile per 50 square feet	١ - ازالة بلاط السقف للفحص البصري يقتصر على البلاط لكل ٥٠ قدم مربع
	2-Painting (but no sanding)	٢ - الدهان وليس الصنفرة
	3- Wall covering, electrical trim work, minor plumbing, and activities which do not generate dust or require cutting of walls or access to ceilings other than for visual inspection	٣ - تغطية الجدران ، أعمال القطع الكهربائية ، السباكة الصغيرة ، والأنشطة التي لا تولد الغبار أو تتطلب كسر في الجدران أو الوصول إلى السقوف الأخرى خلال الفحص البصري
Type B النوع الثاني Small scale, short duration activities which create minimal dust. Includes, but is not limited to: الأنشطة الصغيرة وذات المدة القصيرة والتي تسبب غبار بسيط على سبيل المثال	1- Installation of telephone and computer cabling	١ - تركيب كابلات الهاتف والكمبيوتر
	2- Access to close spaces	٢ - الوصول إلى المساحات المغلقة
	3- Cutting of walls or ceiling where dust migration can be controlled	٣ - قطع الجدران أو السقف حيث يمكن التحكم في السيطرة الغبار
Type c النوع الثالث Work which generates a moderate to high level of dust or requires demolition or removal of any fixed building components or mbliies, including, but not limited to: العمل الذي يولد مستوى معتدل إلى مرتفع من الغبار أو يتطلب إزالة أو إزالة أي مكونات أو تركيبات للمباني الثابتة ، بما في ذلك ، على سبيل المثال لا الحصر	1- Sanding of walls for painting or wall covering	١ - صنفرة الجدران للدهان أو تغطية الحائط (ورق حائط)
	2- Removal of floor coverings, ceiling tiles and caseworks	٢ - إزالة بلاط الأرضيات وبلاط السقف وحوايات
	3- New wall construction	٣ - بناء جدار جديد
	4- Minor duct work or electrical work above ceilings	٤ - عمل بسيط أو عمل كهربائي فوق السقوف
	5- Any activity which cannot be completed within a single work shift	٥ - أي نشاط لا يمكن إكماله في نوبة عمل واحدة
	6- Painting in medium and high risk areas	٦ - طلاء في المناطق ذات المخاطر المتوسطة والعالية
	7- Moderate to high level of noise (cutting steel)	٧ - يرقى إلى مستوى عال من الضوضاء والازعاج ((قطع الصلب))
Type d النوع الرابع Major demolition and construction projects including, but not limited to: مشاريع الهدم والتشييد الرئيسية بما في ذلك على سبيل المثال	1- Activities which require consecutive work shifts	١ - الأنشطة التي تتطلب التحول في العمل (كنقل قسم إلى قسم)
	2- Requires heavy demolition or removal of a complete cabling system.	٢ - يتطلب هدمًا ثقيلًا أو إزالة نظام كابلات كامل.
	3- New construction	٣ - بناء شامل وجديد

Appendix 02-B Determining Patient Risk Groups That Will Be Affected By The Construction / Renovation

نموذج تحديد مجموعات الخطر على المرضى الذين سوف يتأثرون من عملية الترميم / البناء

Group 1 Low Risk المجموعة ١ منخفضة المخاطر	Office areas	المكاتب الادارية
	Non-patient areas	النطاق الغير خاص بالمرضى
Group 2 Medium Risk المجموعة ٢ متوسطة المخاطر	Patent areas not listed in Group 3 or4	المناطق التي ليست في المجموعة رقم ٣ أو ٤
	Public corridors (thoroughfare for patients-supplies)	الممرات العامة (الطريق العام للمرضى والتأمين)
	Admission / discharge	ممرات قسم التنويم
	Laboratories not specified in Group 3	اقسام المختبر الغير محددة في المجموعة ٣
	Dietary	التغذية
	MRI	الرنين المغناطيسي
Group 3 High Risk المجموعة ٣ عالية المخاطر	Emergency room	قسم الطوارئ
	Radiology	الاشعة
	Labor and delivery	النساء والولادة
	Microbiology / Virology laboratories	غرفة الفيروسات او الاحياء الدقيقة بقسم المختبر
	Outpatient surgery	عيادة الجراحة
	Pediatrics	قسم الاطفال
	Pharmacy	الصيدلية
	Surgical units	قسم الجراحة
Group 4 Highest Risk المجموعة ٤ أعلى مخاطرة	CSSD	التعقيم
	Negative pressure isolation rooms	غرفة العزل ذات الضغط السالب

Operating rooms

العمليات

Appendix IPC41-04

Follow –Up For Construction Permit -- نموذج متابعة امر التصريح

Date of follow –up rounds conducted	تاريخ المتابعة	
Location	الموقع	
Permit No	رقم التصريح	
Finding		
Recommendation		
Inspected by		
Signature:	IP&C STAFF NAME:----- (Name & Signature)	
Director:		
Signature:	IP&C STAFF NAME:----- (Name & Signature)	

Appendix IPC41-04

Follow –Up For Construction Permit -- نموذج متابعة امر التصريح

Date of follow –up rounds conducted	تاريخ المتابعة	
Location	الموقع	
Permit No	رقم التصريح	
Finding		
Recommendation		
Inspected by		
Signature:	IP&C STAFF NAME:----- (Name & Signature)	
Director:		
Signature:	IP&C STAFF NAME:----- (Name & Signature)	



Kingdom of Saudi Arabia
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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTRDEPARTMENTAL POLICY PROCEDURE			
IPP VERSION:1	POLICY NUMBER:	IPP: IPC-054	APPLIES TO: HOSPITAL WIDE
	TITLE:	WASTE MANAGEMENT	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 7

1.0. PURPOSE:

- 1.1. To define the method for handling, transporting, and disposing of infectious waste to ensure cost reduction and the safety of HCWs, sanitation workers, and the general public.
- 1.2. provide a process governing the management of infectious and non-infectious medical waste including monitoring and control methods for safe handling, storage, labeling, segregation, reporting, transportation, safe disposal and treatment processing in accordance with the health and safety guidelines, laws and regulations

2.0. DEFINITION:

- 2.1. **Medical waste** - is defined as: potentially infectious waste materials generated at health care facilities, such as hospitals, clinics, physician's offices, dental practices, blood banks, and etc.

3.0. POLICY:

- 3.1. All staffs must comply with the proper waste segregation.
- 3.2. Infectious waste (also called medical, biomedical, regulated or biohazard waste) is defined as materials generated as a result of the diagnosis or treatment of a patient and that is capable of producing an infectious disease.
- 3.3. The risk of acquiring an infection from medical waste is extremely remote. No waste disposal worker or member of the general public has ever acquired an infection from medical waste.
- 3.4. In general, the microbial load of hospital waste is less than that of residential waste.
- 3.5. Careless designation and disposal of all hospital waste as "infectious waste" by HCWs leads to unnecessary consumption of hospital resources to manage such waste.
- 3.6. Infectious waste has been specifically defined by regulatory authorities such as the Centers for Disease Control (CDC) and the Environmental Protection Agency (EPA). For any infectious waste to be capable of causing infection, a susceptible host must be exposed to a pathogen in the waste and must have a portal of entry, and the pathogen must be of sufficient virulence and quantity.



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4.0. RESPONSIBILITY:

- 4.1. Hospital department responsible for waste collection and disposal .
- 4.2. The Department of Infection Prevention & Control will assist with staff education and the hospital's auditing office will monitor and give feedback.

5.0. PROCEDURE:

- 5.1. A. Three methods of waste segregation must be followed at the point of generation (i.e., by the end user).

5.1.1. BLACK bags

- 5.1.1.1. Used to dispose of general hospital waste.
- 5.1.1.2. Items that would not release (drip) blood or other potentially infectious materials in a liquid or semi-liquid state if squeezed.
- 5.1.1.3. Place solid waste not grossly contaminated with potentially infectious blood or body fluids from isolation rooms or operating rooms in black bags.
- 5.1.1.4. Laboratory solid waste, not included in the infectious waste category.

5.1.2. YELLOW bags

- 5.1.2.1. Used to dispose of infectious waste.
- 5.1.2.2. Containers with blood/body fluids that cannot be emptied.
- 5.1.2.3. All microbiological waste (specimens, cultures, and stocks of etiologic agents).
- 5.1.2.4. Items moderately or heavily soaked (dripping) in blood or body fluids.
- 5.1.2.5. Chemotherapy waste.
- 5.1.2.6. Place infectious waste in the appropriate designated container, lined with yellow disposal bags.
- 5.1.2.7. One garbage bin lined with a yellow disposal bag can be kept in the dirty utility room of non-ICU units or areas.

5.1.3. SHARPS containers

- 5.1.3.1. Used to dispose all needles, scalpels, pipettes, syringes, and glass items.
- 5.1.3.2. Do not disassemble blades or needles from equipment.



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5.1.3.3. Discard sharps so that they do not protrude from the opening of the container.

5.1.3.4. Replace the sharps container promptly when the sharps container is $\frac{3}{4}$ filled and reaches the fill line.

5.1.4. **RED bags**

5.1.4.1. Use to transport body parts, organs, or fetuses for burial.

5.2. **Healthcare workers**

5.2.1. Discard all waste generated in your area into the appropriate bin.

5.2.2. Wearing the appropriate protective apparel, carefully pour potentially infectious liquid waste down the drain.

5.2.3. Care should be given not to generate splashes that may contaminate yourself and the surrounding environment.

5.2.4. Hand hygiene sinks should not be used to dispose of such fluids.

5.4.5. Place empty bulk blood and blood product containers in black bags.

5.4.6. Perform hand hygiene immediately after body fluid exposure.

5.3. **Environmental services (Housekeeping services)**

5.3.1. Pick up waste at least once per day and as needed.

5.3.2. Handle bags at the top so that the bags do not come in contact with your body. Do not use your hands to compress (squeeze) waste in containers/bags.

5.3.3. Tie bags securely before placing them in a temporary holding area such as a dirty utility room. Do not store waste bags in hallways or corridors.

5.3.4. Replace the sharps container promptly when it is $\frac{3}{4}$ full or reaches the fill line.

5.4.5. Fasten the cover of a full sharps container securely before removing.

5.4.6. Decontaminate disposal bins/containers or frames when visibly soiled. These items should be cleaned weekly with hospital-approved disinfectant.

5.4.7. Decontaminate carts used for transporting waste within the hospital daily using a hospital-approved disinfectant solution.

5.4.8. Use leak-proof carts that are readily cleanable to transport infectious waste from the point of generation or storage to the point of disposal and treatment.

5.4.9. Place yellow bags in a holding area for incineration.

5.4.10. Pick up and discard broken glass using a mechanical device such as forceps or a brush and dust pan. Broken glass should never be handled with gloved or non-gloved hands.

5.4.11. Clean blood spills according to a written procedure (see "Blood Spills Cleaning" below).

5.4. **Blood Spills**



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5.4.1. All work locations where employees may come into contact with blood or other potentially infectious material must have equipment/kits available to safely and effectively clean up any spills. This kit must include the following:

5.4.1.1. Personal protective equipment (PPE): gown, gloves, eyewear, mask, forceps, plastic scoop, absorbent material, and yellow bags.

5.4.1.2. Sharps container and approved hospital disinfectant (bleach).

5.4.2. Procedure

5.4.2.1. The steps described below should be taken when cleaning and decontaminating spills of blood or other potentially infectious materials:

5.4.2.1.1. When an infectious/medical waste spill has been identified, perform the following steps:

5.4.2.1.1.1. **Control** access to area

5.4.2.1.1.2. **Contain** the spill with paper towels or other absorbent materials

5.4.2.1.1.3. **Contact** housekeeping to disinfect the area

5.4.2.1.2. **Control** access to area: Prevent people from walking through affected area and spreading the blood or other potentially infectious material to other areas.

5.4.2.1.2.1. Put on appropriate PPE

5.4.2.1.2.2. Use forceps, a plastic scoop, or other mechanical means to remove any broken glass or other sharp objects from the spill area.

5.4.2.1.2.2.1. Never pick up sharps with your hands.

5.4.2.1.2.2.2. Take care not to create aerosols.

5.4.2.1.2.2.3. Place sharp objects carefully in sharps container.

5.4.2.1.3. **Contain** spill: Use paper towels or other absorbent materials to contain the spill.

5.4.2.1.3.1. Apply the appropriate disinfectant. To avoid creating aerosols, never spray disinfectant directly onto the spilled material. Instead, gently pour disinfectant on top of paper towels covering the spill or gently flood the affected area, first around the perimeter of the spill, then working slowly toward the spilled material. If sodium hypochlorite solution (5.25% household chlorine bleach) is used, prepare a fresh solution on a daily basis.

5.4.2.1.3.1.1. Leave for the recommended contact time.

5.4.2.1.3.1.2. Pick up all absorbent material and carefully place in a yellow bag for disposal. Remove PPE and place in a yellow bag for disposal.



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5.4.2.1.3.1.3. Seal the yellow bag.

5.4.2.1.3.1.4. Wash hands thoroughly with soap and water.

5.4.2.1.4. **Contact** housekeeping to clean the affected area with hospital-approved disinfectant.

5.4.3. SPILLS occurring within the biosafety cabinet

5.4.3.1. When infectious material is spilled within the biosafety cabinet, it should be cleaned up immediately by the individual performing the work. If the cabinet is certified and working properly and not overfilled with lab equipment, which limits the cabinet's air flow, there is little risk of aerosolization of the material into the general laboratory environment.

5.4.3.2. Additionally, employees working with potentially infectious microorganisms must wear adequate personal protective equipment (PPE).

5.4.3.3. When cleaning and decontaminating a spill within a biosafety cabinet, care should be taken not to move hands and arms into and out of the cabinet unnecessarily. This action creates turbulence that reduces the laminar air flow characteristics and the effectiveness of the biosafety cabinet. A suitable disinfectant and laboratory wipes should always be available within the cabinet or on the supply cart or table directly adjacent to the biosafety cabinet.

5.4.3.4. Procedure

5.4.3.4.1. To effectively clean and decontaminate a spill within the biosafety cabinet follow these steps:

5.4.3.4.1.1. With cabinet air flow running, cover the affected area immediately with absorbent material.

5.4.3.4.1.1.1. Using hospital-approved disinfectant, gently spray the top of the covered spill.

5.4.3.4.1.1.2. Leave for the recommended contact time.

5.4.3.4.1.1.3. Pick up the absorbent material and place in a small autoclave bag inside the biosafety cabinet.

5.4.3.4.1.1.4. Clean the affected area again with disinfectant. If chlorine bleach is used, the affected area should be cleaned with 70% ethanol afterward to remove residual bleach. Chlorine bleach will pit and corrode the stainless steel work area inside the biosafety cabinet.

5.4.3.4.1.1.5. Place the sealed bag in a biohazard waste receptacle.

6.0. MATERIALS/EQUIPMENT:

6.1. Medical waste bin

6.2. Sharp container



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6.3. Waste plastic/bag (yellow and red)

6.4. Spill kit

7.0. REFERENCE:

7.1. GCC Manual for Infection Control 3rd Edition Manual(2018)

7.2. MOH (Ministry of Health)

8.0. APPROVALS :

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Mansor Rajhi	FMS Director		8-7-2021
Concurred	Dr . Shawgy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr . Shawagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



Appendix 01: Summary of Infectious/Hazardous Waste Management Plan

IV Tubing and syringes:				
IV Tubing and syringes :	Hazard-Sharp Items	Black Bag	Infectious Waste	Cytotoxic Waste
Iv tubing used for blood and blood product			✓	
Iv tubing used for cytotoxic and chemotherapy				✓
Iv tubing NOT used for blood , blood product, cytotoxic nor chemotherapy		✓		
syringes without needle and used for blood and blood product			✓	
syringes without needle and used for cytotoxic and chemotherapy				✓
syringes without needle and NOT used for blood , blood product, cytotoxic nor chemotherapy		✓		
syringes with needle	✓			

Patient Care Related Waste Items	Hazard-Sharp Items	Black Bag	Infectious Waste	Cytotoxic Waste	Comments
Adaptic		√			
Adult ambboards		√			
Alcohol swab		√			
Angiocath (with needle)	√				
Antimicrobial skin cleanser kit		√			
Applicator e.g. CHG Applicator		√			
Arterial catheter(without needle)		√			
Bag water soluble		√			
Bandage		√			
Bandage stretch		√			
Band-aids strip		√			
Bedpan		√			
Bile bag with drainage		√			Drain contents into hopper or toilet
Biohazard Transport bag		√			
Bite stick		√			
Blood /Blood products tubing and bags			√		
Blood gas analyzer cartridge container			√		
Blood gas syringes with needle	√				
Body Lotion		√			

Brown bag paper		√			
Butterfly needle	√				
Cath/drainage tube plug protector		√			
Catheter leader		√			
Chest tube			√		
Chux underpads		√			
Closed chest drainage system adult/pediatric			√		
Comb		√			
Connecting tubing		√			
Cotton ball large		√			
CVC kit	√	√	√		Packaging: Black bag Needle: Sharps bin
					Tubing removed from patient: yellow bag
CVP change dressing kit		√			
Denture container		√			
Dialysis tubing and dialyzer			√		
Drape (fenestrated and non-fenestrated)		√			
Drape sheet large		√			
Duodenal tube		√			
ECG electrodes		√			
ECG monitor paper		√			
Egg crate bed pad		√			
Elastic stockings		√			
Endotracheal tubes		√			

Enema kit		√			
Enteral feeding tubing		√			
Extension tubing		√			
Eye pad oval		√			
Eye shield alum		√			
Feeding pump tube		√			
Filter needle	√				
Foley catheter tray		√			
Foley catheter tray with drainage system		√			
Foley catheter		√			
Gastrostomy Tube		√			
Gauze		√			
Gel intrasite		√			
Gloves		√			
Gowns		√			
Heel protector		√			
Hemovac drain			√		Drain contents into hopper or toilet
Hypodermic needle	√				
Irrigation tray/basin container & piston syringe		√			
dishes / trays		√			
IV cannula needle	√				
IV cannula w/ extension piece	√				
IV tubing		√			

Jackson Pratt drain		√			Drain contents into hopper or toilet
Kidney Basin		√			
Lancing Device Regular	√				
Limb holder		√			
Lumbar puncture tray	√	√			Packaging: Black bag Needle: Sharps bin
Male urinal		√			After emptying
Male/female adapter		√			
Mask w/ splash guard		√			
Maternity pad sterile wrapped		√			
Measuring Tape Paper		√			
Medication cup		√			
Mucous trap w/tubing/suction port			√		
N95 respirator mask		√			
Nasogastric tube		√			
Neuro external drainage collection set	√	√			Packaging: Black bag Introducer: Sharps bin
Neuro external drainage ventricular cath kit	√	√			Packaging: Black bag Introducer: Sharps bin
Pack mortuary large adult		√			
Paper towels		√			
PCA tubing			√		
Penrose drain		√			
Percutaneous sheath introducer port kit	√	√	√		Packaging: black bag Needle: Sharps bin

					Tubing removal from patient: yellow bag
Peripad		√			
Petrolatum gauze		√			
Pleuro vac drain			√		
PLT infusion tubing micron filter			√		
Percutaneous drain sponge		√			
Pressure monitor		√			
Dressing		√			
Pulmonary artery catheter kit	√	√	√		Packaging: black bag Needle: Sharps bin
					Tubing removal from patient: yellow bag
Quinton catheter set	√	√	√		Packaging: black bag Needle: Sharps bin Tubing removal from patient: yellow bag
Radial artery cath suture wing clip kit	√	√	√		Packaging: black bag Needle: Sharps bin Tubing removal from patient: yellow bag
Disposable cutting head piece of the clipper	√				
Safety pin	√				
Salem sump tube		√			
Sanitizer Air		√			
Scalpel	√				
SCD stocking knee sleeve		√			
Scissors	√				

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Silk tape		√			
Skin closure strips		√			
Skin stapler remover	√				
Slippers		√			
Soap		√			
Soap Dish		√			
Spinal needle	√				
Stockinette		√			
Suction canister liner with fluid			√		
Suction cath kit		√			
Suction tray		√			
Suction Catheter		√			
Surgical cap		√			
Surgical gown cuffed w/hand towel sterile		√			
N95 Respirator	√				
Surgical mask		√			
Suture removal tray	√	√			Scissors: Sharps bin
					Plastic forceps/packaging: Black bag
Suture silk without needle		√			
Suture silk with needle	√				
Swabstick alcohol		√			
Swabstick chlorahex gluc		√			
Swabstick povidone-iodine		√			

Syringe with needle	√				
		√			
		√			
Thoracentesis tray	√	√			Packaging: black bag Needle: Sharps bin
Tissue Facial		√			
Tongue depressor		√			
Toothettes		√			
Tracheostomy tube		√			
Tracheostomy/ETT Holder		√			
Tracheostomy tray	√	√			Packaging: black bag Needle: Sharps bin
Transducer kit standard	√	√			Packaging: black bag Needle: Sharps bin
Tubing "Y" type connecting set		√			
Tubing extension set		√			
Tumbler 8oz		√			
Twill cloth tape		√			
Urinary drainage bag		√			Drain contents into hopper or toilet
Urine meter		√			
Urine specimen collection bag		√			
Ventilator Circuit/Adaptors/Connec tions		√			
Vest restraint		√			
Wash Basin		√			

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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

DEPARTEMNTAL POLICY PROCEDURE			
DPP VERSION:1	POLICY NUMBER:	DPP: IPC-055	APPLIES TO: HOSPITAL WIDE
	TITLE:	SPILL (BLOOD AND BODY FLUID) MANAGEMENT	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 3

1.0. PURPOSE:

- 1.1.To provide guidelines to prevent infection from blood and body fluid spillages in all areas including the Laboratory, Wards, ER, ICU, OPD.

2.0. DEFINITION:

- 2.1. **Spill kit** - used to control, contain and clean up spills. Spill kit components are easily replaced individually and can be modified to suit individual requirements.

3.0. POLICY:

- 3.1. All blood and body fluids will be considered infectious.
- 3.2. A Spill Kit should be available in all patient care units.
- 3.3. Applies to all spills less than 250 ml in volume.

4.0.RESPONSIBILITY:

- 4.1. It is responsibility of the staff to know the proper use of spill kit.

5.0. PROCEDURE:

- 5.1. Immediately confine the area of spill using appropriate warning signs to avoid accidental contact by other people.
- 5.2. Take the Spill Kit and place it conveniently near to the spill area but not on the floor where it may be accidentally stepped on.
- 5.3. Wear PPE (gown, face mask with shield, gloves) to avoid contamination.
- 5.4. Open the absorbent pack and sprinkle entire contents of the absorbent material evenly over bodily fluid spill.
- 5.5. Allow for three (3) minutes contact time. Use scoop/scrapper to pick up material and put into Biohazard Bag.
- 5.6. Take the solution bottle with one evervesent sodium dischloro isocianurate tablet (Presept) then fill with water till level. Do not shake. Dissolve by inverting the container.



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

DEPARTEMNTAL POLICY PROCEDURE

DPP

VERSION:1

POLICY NUMBER:	DPP: IPC-055	APPLIES TO: HOSPITAL WIDE
TITLE:	SPILL (BLOOD AND BODY FLUID) MANAGEMENT	
APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
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- 5.7. Dispense Presept on the area of spill by pouring sufficient amount to cover the entire area of the spill. Make sure no wet areas are visible. Wipe the granules with paper towels and dispose in the yellow bag.
- 5.8. Dispose all the items in the yellow bag.
- 5.9. Wash hands with antiseptic soap and water.

6.0. MATERIAL/EQUIPMENT:

- 6.1. Disposable non-woven gown and gloves
- 6.2. Face mask with shield
- 6.3. Yellow bag with fastener
- 6.4. Absorbent powder in container
- 6.5. Towel
- 6.6. Mini dust pan and brush (scoop and scrapper)
- 6.7. Bottle + Presept tablet
- 6.8. Spill sign board

7.0. REFERENCE:

- 7.1. CDC (Center for Disease Control), Guidelines for environmental infection control for healthcare facilities, 2003
- 7.2. Ministry of Health, Saudi Arabia, Healthcare Facilities Housekeeping Policy, 2009
- 7.3. Presept ® Hard Surface Disinfectant Products, J&J C, <http://www.jnj.com>



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	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
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8.0. APPROVALS :

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Hadi Awaji	Environment Health supervisor		8-7-2021
Concurred	Dr . Shawagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khibrani	Quality Director		13-7-2021
Approved by:	Dr .Shawagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





DEPARTMENT OF INFECTION PREVENTION AND CONTROL

DEPARTEMENTAL POLICY PROCEDURE

DPP VERSION:1	POLICY NUMBER:	DPP: IPC-056	APPLIES TO: HOSPITAL WIDE
	TITLE:	MEDICAL STORGE	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
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0.0. PURPOSE

- 1.1 To prevent contamination of cleaning and sterile supply stored in clinical area using the relevant ministry of health standards as a guide

1.0. DEFINITION

- 2.1 Medical store : is a place where medical supply are stored.

2.0. POLICY

- 2.1. Medical storage areas are of adequate capacity, regularly cleaned, secured and away from contamination, air vents and direct sunlight.
- 2.2. Medical storage areas should controlled Ventilation with adjusted temperature and humidity which temperature ranges from 22 C to 24 C and humidity up to 70%.
- 2.3. Temperature and humidity should be documented daily.
- 2.4. Storage shelves are at least. 40 Cm from the ceiling, 20 cm from the floor, and 5cm from the wall.
- 2.5. Storage shelves should be made of easily cleaned material such as, fenestrated stainless steel or Aluminum.
- 2.6. Sterile and clean items should be completely separated from personal items, foods, and drinks.
- 2.7. No items are kept in the original shipping boxes, especially the clinical area.
- 2.8. Medical store should be inspected regularly for evidence of pests.
- 2.9. Medical store should be cleaned regularly and documented.

3.0. RESPONSIBILITY

- 3.1. Head Of Department To Check T, Humidity Every Day
- 3.2. IPC Team To Monitoring Check Paper

5.0. PROSEDURE

N/A



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DPP

VERSION:1

POLICY NUMBER:	DPP: IPC-056	APPLIES TO: HOSPITAL WIDE
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6.0. ATTACHEMENT

N/A

7.0. REFERENCE

7.1. MOH Infection control tools ICA 2020

8.0. APPROVAL

	NAME	POSITION	SIGNA TURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Hassn obairi	Medical store supervisor		8-7-2021
Concurred	Dr . Shawagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. AISHA Khubrani	Quality Director		13-7-2021
Approved by:	Dr .Shawagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al- Harthi	Hospital Director		26-7-2021





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1.0. PURPOSE

- 1.1.To develop and maintain effective and efficient cleaning methods and schedules which are necessary to provide a clean healthy environment for patients, staff and visitors.

2.0.DEFINITION

- 2.1. N/A

3.0.POLICY

- 3.1.There will be an appropriate written schedule for cleaning and decontamination of all areas of the hospital.
- 3.2.Routine cleaning procedures shall be effective and consistent.
- 3.3.Cleaning products shall be selected on the basis of uses, efficacy, acceptability, safety and cost.
- 3.4.All cleaning products shall be approved by the IP&C and their MSDS available for reference. All chemicals used by Environmental Services shall be approved by EHOHS through the related MSDS prior to any use or purchase.
- 3.5.Cleaning activities shall minimize turbulence to prevent the dispersion of dust that may contain microorganisms.
- 3.6. All housekeeping staff shall be made aware of and adhere to isolation precautions in patient care areas.

4.0.RESPONSIBILITY

- 4.1.Contract managers and supervisors must assess the competency of employees by observing the techniques of the worker using written criteria that have been previously explained and demonstrated to the employee. If literacy and/or proficiency in English is not a problem, written tests can be administered.
- 4.2.All Housekeeping Managers and Supervisors who are responsible for the selection and use of cleaning products and the education of their staff shall have an understanding of the differences between a disinfectant detergent and a non-disinfectant cleaning agent.
- 4.3.Infection Prevention & Control especially its Environmental Health and Occupational Health & Safety Section must have a thorough knowledge of the cleaning agents and disinfectants used by Housekeeping Services.
- 4.4.Environmental Services must comply with all the applicable regulations and standards of hospital.
- 4.5.EHOHS, IPC, OSHA and other related national and international safety regulations to prevent potential contamination, minimize risk and maintain safe environment.

5.0.PROCEDURE



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5.1. **Standard Precautions**- All housekeeping staff shall adhere to Standard Precautions when cleaning a room.

5.2. **Transmission-based Precautions** - All housekeeping staff shall adhere to airborne, droplet and contact precautions when cleaning a room.

5.3. **Personal Protective Equipment** - Gloves shall be worn when performing any cleaning activities. Disposable gloves shall be used except where there is a high risk of percutaneous injury when heavy-duty gloves shall be worn. Personal protective equipment shall be worn according to transmission-based isolation precautions used in patient's room.

6.0. MATERIALS AND EQUIPMENTS

6.1. GUIDELINES

6.1.1. Principles and Methods of Disinfection of Equipment and Supplies

(Factors Affecting Disinfectant Activity):

6.1.1.1. Concentration of Disinfectant: In general, the more concentrated, the greater the killing capacity of a chemical. However, the higher the concentration, the more likely a chemical will damage the surface that it is designed to disinfect.

6.1.1.2. A successful product must be effective at a low but sufficient concentration to avoid corrosion, staining, or other damaging effects to inanimate surfaces, hands, and mucous membranes of the personnel.

6.1.1.3. If the concentration is too low, the killing capacity of the chemical is decreased.

6.1.1.4. The greater the number of microbes present, the more difficult the surface is to disinfect.

6.1.2. Cleanliness of the Surface

6.1.2.1. (Basic Principles)

6.1.2.1.1. Physical protection of the microbe is afforded by soil. The disinfectant must penetrate the microbial cell to destroy it.

6.1.2.1.2. Organic matter may contain large numbers of bacteria.

6.1.2.1.3. Organic matter may inactivate the disinfectant; therefore, cleaning must precede disinfection.

6.1.2.1.4. Residual detergents from cleaning may inactivate the disinfectant; therefore rinsing is important.



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6.1.2.1.5. Disinfection requires that the object to be disinfected have direct contact with the wet disinfecting agent for a specified time.

6.1.2.1.6. The exact contact time required depends on the disinfectant used and all the other factors that affect disinfectant activity.

6.1.2.1.7. The number of surviving organisms decreases with time of exposure to the disinfectant.

6.1.2.1.8. Water hardness – the presence of soluble calcium or magnesium compounds in water; they react with soap to form an insoluble precipitate and tend to neutralize some disinfectants.

6.1.2.2. Resources Required :

6.1.2.3. Approved disinfectants, disinfectant detergents and non-disinfectant cleaning agents.

6.1.2.4. Personal protective equipment.

6.1.2.5. Adequate supply of cleaning equipment.

6.1.3. Principles of Cleaning and Disinfecting Environmental Surfaces :

6.1.3.1. Environmental surfaces include medical equipment surfaces and housekeeping surfaces.

6.1.3.2. Although microbiologically contaminated surfaces can serve as reservoirs of potential pathogens, these surfaces are generally not directly associated with transmission of infections to either staff or patients. The spread of microorganisms from environmental surfaces to patients is largely via hand contact with the surface. While hand hygiene is important to minimize the impact of this spread, cleaning and disinfecting environmental surfaces as appropriate is fundamental in reducing their potential contribution to the incidence of healthcare associated infections.

6.1.3.3. According to the Spaulding classification, environmental surfaces are “non-critical” surfaces that generally do not come into direct contact with patients during care. These surfaces carry the least risk of disease transmission and can be safely decontaminated using less rigorous methods of disinfection. Low-level disinfectants also referred to as sanitizers, are satisfactory and these include quaternary ammonium compounds, some phenolics, and some iodophors.



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6.1.3.4. Germicidal chemicals cleared as skin antiseptics are not appropriate for use as environmental surface disinfectants.

6.1.3.5. Cleaning is the necessary first step of any sterilization or disinfection process. Cleaning is a form of decontamination that renders the environmental surface safe to handle or use by removing organic matter, salts, and visible soils, all of which interfere with microbial inactivation.

6.1.3.6. The physical action of scrubbing with detergents and surfactants and rinsing with water removes large numbers of microorganisms from surfaces. If the surface is not cleaned before the terminal reprocessing procedures are started, then the success of the disinfection process is compromised.

6.1.4. Strategies for Routine Cleaning of Medical Equipment :

6.1.4.1. Manufacturers of medical equipment should provide care and maintenance instructions specific to their equipment. These instructions should include information about materials compatibility with chemical germicides, whether or not the equipment can be safely immersed for cleaning, and how the equipment should be decontaminated if servicing is required.

6.1.4.2. Barrier protection of surfaces and equipment is useful, especially if these surfaces are:

6.1.4.2.1. Touched frequently by gloved hands during the delivery of patient care;

6.1.4.2.2. Likely to become contaminated with body substances;

6.1.4.2.3. Difficult to clean.

6.1.4.2.4. Impervious-backed paper, aluminum foil, plastic or fluid-resistant covers are suitable for use as barrier protection.

6.1.5. Strategies for Routine Cleaning of Housekeeping Surfaces :

6.1.5.1. Housekeeping surfaces require regular cleaning and removal of soil and dust using a detergent/disinfectant.

6.1.5.2. Extraordinary cleaning and decontamination of floors in healthcare settings is unwarranted. Studies have demonstrated that disinfection of floors offer no significant advantage over regular detergent/water cleaning and has little or no impact on the occurrence of healthcare-associated infections. Further, newly cleaned floors become rapidly re-contaminated from airborne



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microorganisms and those transferred from shoes, equipment wheels, and body substances.

6.1.5.3. Cleaning methods that produce minimal mists and aerosols or dispersion of dust in patient-care areas are preferred.

6.1.5.4. Part of the cleaning strategy is to minimize contamination of cleaning solutions and cleaning tools. Bucket solutions become contaminated almost immediately during cleaning, and continued use of the solution transfers increasing numbers of microorganisms to each subsequent surface to be cleaned. Cleaning solutions should be replaced frequently. Laundering of cloths and mop heads after use and allowing them to dry before re-use, can help to minimize the degree of contamination.

6.1.5.5. Another reservoir for microorganisms in the cleaning process may be dilute solutions of the detergents or disinfectants, especially if the working solution is prepared in a dirty container and stored for long periods of time.

6.1.6. Recommendations for Routine

6.1.6.1. Cleaning of Housekeeping Surfaces

6.1.6.2. Do not use high-level disinfectants/liquid chemical sterilants on non-critical surfaces for disinfection.

6.1.6.3. Keep housekeeping surfaces (e.g. floors, walls, tabletops) visibly clean on a regular basis and as spills occur.

6.1.6.4. Use an EPA registered hospital grade disinfectant/detergent designed for general housekeeping purposes.

6.1.6.5. Follow manufacturers' instructions for proper use of cleaning/disinfecting products, paying close attention to specified use dilutions and stated contact times.

6.1.6.6. Never mix different housekeeping solutions.

6.1.6.7. Clean and disinfect high touch surfaces (e.g. door knobs, bed rails, light switches, surfaces in and around toilets in patients' rooms) on a more frequent schedule compared to that for minimal touch housekeeping surfaces (see Housekeeping DPP).

6.1.6.8. Clean walls, blinds, and window curtains inpatient care areas when they are visibly dusty or soiled.

6.1.6.9. Do not use disinfectant fogging for any purposes in patient care areas.

6.1.6.10. Avoid large-surface cleaning methods that produce mist or aerosols or disperse dust in patient care areas.



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- 6.1.6.11. Follow proper procedures for effective use of mops, cloths, and solutions:
- 6.1.6.12. Prepare cleaning solutions daily or as needed, and replace with fresh solutions frequently.
- 6.1.6.13. Use clean mops and cloths every time a bucket of cleaning solution is emptied and replenished with clean, fresh solution.
- 6.1.6.14. Clean mops and cloths after use and allow to dry before reuse or use single-use, disposable mop heads and cloths.
- 6.1.6.15. Mop heads should be sent to the laundry on a daily basis.
- 6.1.6.16. After the last surgical procedure of the day or night, wet vacuum or mop the operating room floors with a single use mop or a clean mop head and an EPA-registered hospital disinfectant.
- 6.1.6.17. Do not use tacky mats at the entrance to operating rooms or delivery suites.
- 6.1.6.18. Use proper dusting methods for all patient care areas especially for immune suppressed patients' areas.
- 6.1.6.19. Wet-dust horizontal surfaces daily using cloths moistened with an EPA-registered hospital disinfectant.
- 6.1.6.20. Avoid dusting methods that disperse dust (e.g., feather dusting).
- 6.1.6.21. Keep vacuums in good repair and keep vacuums with HEPA filters for use in high-risk patient care areas.
- 6.1.6.22. Close the doors of immune compromised patients' rooms when vacuuming corridor floors to minimize exposure to airborne dust.
- 6.1.6.23. Take precautions when using phenolic disinfectant in neonatal units.
- 6.1.6.24. Prepare solutions to correct concentrations in accordance with manufacturers' instructions or use premixed formulation.
- 6.1.6.25. Do not use phenolics to disinfect bassinets or incubators during an infant's stay.
- 6.1.6.26. Rinse phenolic-treated surfaces with water.

6.1.7. Cleaning Strategies for Spills of Blood and Body Fluids

- 6.1.7.1. Promptly clean and decontaminate spills of blood or other potentially infectious materials.



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6.1.7.2. Follow proper procedures for site decontamination of blood and body fluid spills.

6.1.7.3. Use protective gloves and other personal protective equipment appropriate for this task.

6.1.7.4. If the spill contains large amounts of blood or body fluids, clean the visible matter with disposable absorbent material, and discard the used cleaning materials in appropriate, labeled containment (red bags).

6.1.7.5. Swab the area with a disposable cloth, moderately wet with disinfectant and allow the surface to dry.

6.1.7.6. Use intermediate-level germicides (germicides registered by the EPA for use as hospital disinfectants and labeled tuberculoidal) at recommended dilutions and full contact time to decontaminate spills of blood and other body fluids.

6.1.7.7. Use a one-step cleaning/disinfecting procedure for small spills.

6.1.7.8. If Sodium Hypochlorite solutions (e.g. household chlorine bleach) are selected for use:

6.1.7.8.1. Use a 1:100 dilution (500 ppm available chlorine) to decontaminate non-porous surfaces after cleaning a spill of either blood or body fluids in patient-care settings.

6.1.7.8.2. If a spill involves large amounts of blood or body fluids, or if a blood or culture spill occurs in the laboratory, use a 1:10 dilution (5000 ppm available chlorine) for the first application of germicide before cleaning.

6.1.8. Flowers and Plants in Patient-Care Areas

6.1.8.1. Flowers and potted plants are not to be allowed in patient rooms of immunosuppressed patients.

6.1.9. Some precautions for general public settings are:

6.1.9.1. Limiting the flower and plant care to staff with no direct patient contact

6.1.9.2. Advising hospital staff to wear gloves when handling plants

6.1.9.3. Washing hands after handling plants

6.1.9.4. Changing vase water every two days and discharging the water into a sink outside the immediate patient environment

6.1.9.5. Cleaning and disinfecting vases after use.

7.0. REFERENCES



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- 7.1.1. Environmental Health Manual, Infection Prevention and Control Department, KAMC.
7.1.2. GCC Infection Prevention and Control 3rd Edition Manual (2018)

8.0. APPROVALS

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Mansor Rajhi	FMS Director		8-7-2021
	Mr. Tariq Sweidi	House keeping Supervisor		9-7-2021
	Dr. Shawgy Alhzmi	IPC committee chairman		13-7-2021
Concurred	Ms. Aisha Kubrani	Quality Director		13-7-2021
	Dr. Shawgy Alhzmi	Medical Director		26-7-2021
Approved by:	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



WEEKLY ENVIRONMENTAL ROUND CHECKLIST BY HOUSEKEEPING SUPERVISOR

DEPARTMENT : _____ DATE : ____/____/____

AREA	CLEAN	NOT CLEAN	REMARKS
Patient Area or Rooms	Bedside Table		
	Patient Bed		
	Chair		
	Overbed Light		
	Floors		
	Doors/Door Handles		
	Non – medical Waste Container		
	Windows		
	Sinks		
	Ceiling		
	Refrigerator		
	Handrub Dispensers		
Hallways	Floors		
	Walls		
	Handrub Dispensers		
Medical Supply Store	Floor and Ceiling		
	Shelves		
Nursing Station	Floor		
	Chairs		
	Bathroom and Sink		
Patient's Room Toilets	Sink		
	Floor, Ceiling and Wall		
	Toilet Bowl		
Equipment Store	Floor and Ceiling		
Medication Room	Floor and Ceiling		
	Surfaces		
	Medication Trolley		
	Waste Containers		
Doctor's Office	Floor and Ceiling		
	Surfaces		
	Chairs		
	Cupboards		
Utility Rooms	Floor and Ceiling		
	Sink		
	Waste Containers		
	Housekeeping Trolley		
	Hamper Trolley		

NOTE: This form to be completed by Housekeeping Supervisor and SUBMIT to Head of Infection Control Department every THURSDAY

Done By : Housekeeping Supervisor

Approved By: Charge Nurse

Signature: _____

Signature : _____

TABLE 02 OCCUPIED ROOM CLEANING

Before cleaning occupied room: <ul style="list-style-type: none"> • Check for isolation status • Always perform hand hygiene • Don appropriate PPE • Check sharps container. Change if necessary • Empty the trash container. Handle plastic bags from top. 	DO NOT WEAR DIRTY GLOVES OUTSIDE THE ROOM If you have to leave the room after you have started a room clean, remove your gloves and perform hand hygiene. Put a new pair of gloves on to resume cleaning.
PATIENT ROOM: Clean and disinfect using disinfectant and cleaning rags.	PATIENT RESTROOM: Clean and disinfect using disinfectant and cleaning rags.
Change rag as needed to ensure saturation NO DOUBLE DIPPING	Change rag as needed to ensure saturation NO DOUBLE DIPPING
PATIENT ROOM: <ul style="list-style-type: none"> • Raise and wipe down arm rails – high touch area • Wipe foot of bed • If the call box or phone is on the bed, wipe down at this time 	PATIENT ROOM: <ul style="list-style-type: none"> • Light switches – high touch area • Door handles, knobs – high touch area • Hand rails – high touch area • Sink and sink counter – high touch area • Clean soap and paper towel dispensers • Wipe shower or tub • Spot walls
CHANGE RAG AND START WITH A FRESH ONE AFTER CLEANING THE BED	CHANGE RAG AND START WITH A FRESH ONE AFTER CLEANING THE TOILET
Move from door and sanitize all equipment (Restroom to be done last) Ledges (below shoulder height) <ul style="list-style-type: none"> • Door handles, knobs • Light switches • Call box • Telephone • Window sills and ledges • Computer keyboard • Soiled linen hamper lid • In-room patient sink and faucet • In-room soap dispenser and paper towel dispenser • Biohazard can • Dry erase marker • Over bed table • Patient chairs • Bedside tables • All other easily accessible wall mounted equipment 	<ul style="list-style-type: none"> • Toilet paper dispenser • Toilet flusher- high touch area • Toilet seat – high touch area • Under the bowl • Toilet rim • Clean the inside of bowl with disinfectant cleaner and toilet brush • Clean commode frame and seat cover LAST
	BEFORE LEAVING THE ROOM: <ul style="list-style-type: none"> • Remove gloves and perform hand hygiene • Restock supplies • Place wet floor sign in the doorway • Mop floor – never shake mop • Perform hand hygiene

TABLE 01 EXAMPLES OF HIGH-TOCH SURFACES

Patient room	Bathroom	Operating room
Bed controls	Bedpan cleaners/flushers	Anesthesia equipment & controls
Bed rails	Call light	Anesthesia supply cart
Bedside table	Doorknobs	Arm boards
Over bed table	Faucet handles	Autoclave door handles
Cabinet knobs	Handrails	Back table
Call light	Hand held shower handles	Computer keyboard
Doorknobs	Light switch	Door handles
IV poles	Sinks	IV poles
Chair	Toilet flush	Light switches
Room sink	Toilet seat	Mayo stand
Telephone		Medication cart
Chair arms/seat		Operating bed
Computer keyboard		Operating bed controls
Handheld Television controls		Operating bed straps
Ventilator controls		Overhead surgical lights
Thermometer		Patient monitors
Blood pressure cuff		Ring stand
		Sponge counter
		Storage cabinet door handles
		Telephone
		Warm door handles



PARTMENT OF INFECTION PREVENTION AND CONTROL

DEPARTEMNTAL POLICY PROCEDURE			
DPP VERSION:1	POLICY NUMBER:	DPP: IPC-058	APPLIES TO: HOSPITAL WIDE
	TITLE:	MEDICAL EQUIPMENT CLEANING AND METHODS OF DISINFECTION	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 4

1.0. PURPOSE:

- 1.1. To provide guidelines for decontamination of soaked medical equipment and its preparation for sterilization or disinfection.
- 1.2. To ensure that the products of CSSD meet the required degree of sterility through regular monitoring and safe, effective distribution procedure of used and sterile items.

2.0. DEFINITIONS:

- 2.1. **Cleaning:** is the removal of all foreign material dirt or organic matter from the object being reprocessed.
- 2.2. **Manual Cleaning:** is the removal of soil or organic matter present in the instruments.
- 2.3. **Disinfection :** is the destruction of pathogenic organisms or their toxins or vectors by direct exposure to chemical or physical agents.
- 2.4. **Mechanical Cleaning:** facilities cleaning and decontamination using cold rinse followed by hot wash then drying with heater.
- 2.5. **Sterilization:** is the destruction of microorganisms including spore forming using steam (flowing or pressurized), chemical agents, high velocity electron bombardment or ultraviolet light radiation.
- 2.6. **Low –level Disinfection :** eliminates vegetative bacteria, some fungi and enveloped viruses. It is used for non – critical medical equipment and some environmental surfaces.
- 2.7. **High – level Disinfection:** eliminates vegetative bacteria, enveloped and non – enveloped viruses, fungi and mycobacteria. It is used for semi – critical medical equipment.



DEPARTMENT OF INFECTION PREVENTION AND CONTROL

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3.0. RESPONSIBILITY

N/A

4.0. POLICY

N/A

5.0. PROSEDURE

- 5.1. Classification of Medical Equipment and Required Level of Processing (Please refer to Appendix **IPC58– 1**)
- 5.2. Respiratory Equipment : Sterile water should be used in humidifiers. Unused water should be discarded. Wall nebulizers and their reservoirs should be cleaned and kept dry when not in use and fill with sterile water when use. Tubing and mask should be changed between patients.
- 5.3. Approved List of Disinfectants and Antiseptics Used in Hospital



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Appendix IPC58– 1

Classification of Medical Equipment and Required Level of Processing

CLASSIFICATION	DEFINITION	LEVEL OF PROCESSING
Non – critical equipment	Equipment that touches only intact skin and not mucous membranes, or does not directly touch the client	Cleaning followed by low – level disinfection. Sometimes cleaning alone is acceptable
Semi – critical equipment	Equipment that comes into contact with non – skin or mucous membranes but does not penetrate them.	Cleaning followed by high – level disinfection at minimum Sterilization is preferred.
Critical equipment	Equipment that enters sterile tissues, including the vascular system.	Cleaning followed by sterilization

6.0. ATTACHMENT

- 6.1. DIPC-058-1 METHOD OF DISINFECTION OF MEDICAL EQUIPMENT
- 6.2. DIPC-058-2 medical equaipment cleaning table

7.0. REFERENCES:

- 7.1. APIC Text of Infection Control and Epidemiology, 2013



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8.0. APPROVAL

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Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021

AL-ALHARTH GENERAL HOSPITAL INFECTION PREVENTION & CONTROL DEPARTMENT

IPC58-02

METHOD OF DISINFECTION OF MEDICAL EQUIPMENT

ITEMS	METHODS	DISINFECTANT/DILUTION	CONTACT TIME	REMARKS
Anesthesia mask assemblies for oxygen and fitting	CSSD or soaking	Cidex – OPA	5 minutes	Send to CSSD for reprocessing
Stainless steel basins	CSSD			Send to CSSD for reprocessing
Stainless steel bedpans	Washing	Soap & water		Send to CSSD for reprocessing
BP cuffs	Washing	Soap & water		Then follow wiping
	Wiping off	Isoprophyl alcohol 70%	Till dry	
Electric apparatus monitors and machine surfaces	Wiping off	Isoprophyl Alcohol 70%	Till dry	
External electrodes	Washing	Soap & water		Then follow wiping off
	Wiping	Isoprophyl Alcohol 70%	Till dry	
Examination tables	Wiping	Sodium hypochlorite 1ml chloring + 100ml water	Till dry	For reprocessing
	CSSD			
Oxygen Hood	Wiping	Sodium Hypochlorite 1ml chlorine + 100ml water	Till dry	
Stainless steel kidney trays	CSSD			For reprocessing
Operating lamps	Wiping	Sodium hypochlorite 1ml chlorine + 100ml water	Till dry	
Operating tables	Wiping	Sodium hypochlorite 1ml chlorine + 100ml water	Till dry	
Stethoscopes	Wiping	Isoprophyl Alcohol 70%	Till dry	

AL-ALHARTH GENERAL HOSPITAL
INFECTION PREVENTION & CONTROL DEPARTMENT

IPC58-02

METHOD OF DISINFECTION OF MEDICAL EQUIPMENT

ITEMS	METHODS	DISINFECTANT/DILUTION	CONTACT TIME	REMARKS
Digital Thermometers	Wiping off	Isoprophyl alcohol 70%	Till dry	
Plastic urinals	Soaking	Sodium hypochlorite 1ml chloring + 100ml water	20 – 30 minutes	Drain till dry
Nurses station	Wiping off	Sodium hypochlorite 1ml chloring + 100ml water	Till dry	
X'ray Apparatus		Sodium hypochlorite 1ml chloring + 100ml water	Till dry	
Wheel chair	Wiping off	Sodium hypochlorite		
Patient bed	Wiping off	1ml chloring + 100ml water		
Patient cabinet	Wiping off	Sodium hypochlorite		
	Wiping off	1ml chloring + 100ml water		
Patients bedside Tables	Wiping off	Sodium hypochlorite		

Department of Infection Prevention and Control

Department:	Month:	2021	IPC CHECKER:
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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

DEPARTEMNTAL POLICY PROCEDURE			
DPP VERSION:1	POLICY NUMBER:	DPP: IPC-059	APPLIES TO: HOSPITAL WIDE
	TITLE:	Management of Disposable, Antimicrobial and Reusable Curtains	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 7

1. PURPOSE

- 1.1 To reduce the risk of infection transmission of the disease.

2. DEFINITION

- 2.1 N/A

3. POLICY

- 3.1 When disposable curtains are used, the replacement of these must be in accordance with the written procedure.
- 3.2 Disposable privacy curtains can only be used in those areas that have been approved by the facility or service executive.

3. RESPONSIBILITY:

- 4.1 Employees will:
- 4.1.1 Ensure that curtains are changed in accordance with the procedure detailed below.
- 4.1.2 Ensure they comply with Workplace Health and Safety requirements during the removal, hanging and disposal of curtains.
- 4.2 Linen Managers will:
- 4.2.1 Ensure adequate supply of curtains are available.
- 4.2.2 Ensure storage of curtains in such a manner as to control access to stock to those areas approved for use.
- 4.2.3 Ensure that curtains are changed in accordance with the procedure outlined in Section 4.
- 4.2.4 undertake compliance audits.

5. PROCEDURES

- 5.1 Hanging disposable curtains
- 5.1.1 Hand hygiene using Alcohol-based hand rub (ABHR)
- 5.1.2 Keep disposable curtains in plastic sleeve .
- 5.1.3 Hold curtain so it does not touch the floor, hang curtain .
- 5.1.4 Write the full date curtain was hung on the label at the top of the curtain.



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5.2 Schedule for changing disposable curtains

5.2.1 Infection Prevention and Control department may request earlier removal if a patient has a communicable illness or rare Multi resistant Organism (MDRO).

5.2.2 As per schedule below or in the following instances

5.2.2.1 When contaminated with blood or other body fluids.

5.2.2.2 If torn or damaged in any way.

5.2.2.3 If visibly soiled .

5.2.2.4 When IP&C has declared the end of an outbreak of Clostridium difficile, Norovirus, or other relevant pathogen, prior to lifting outbreak control measures and measures and transmission based precautions for patients on the ward/unit.

5.3 Frequency of changing curtains

5.3.1 Based on current stock of curtains procured within AHAH. Note that this may change depending on manufacturer's instructions:



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TABLE 1

Area	Disposable curtains	Laundered curtains
Very high risk Outbreak of unknown infectious disease or gastroenteritis/ <i>Clostridium difficile</i> , novel communicable disease or rare MDRO, novel influenza, carbapenem-resistant Enterobacteriaceae (CRE), Vancomycin Resistant Enterococcus (VRE), Methicillin-resistant Staphylococcus aureus (MRSA wards managing patients with MERS Co. or highly transmissible communicable diseases	Change immediately upon discharge of the patient and dispose	Change immediately upon discharge of the patient
High risk Emergency Department Operating suites,	Six monthly or as directed by Infection Prevention and Control department or if they are visibly soiled or torn	Change twice per month and immediately if visibly soiled
Significant risk General wards	Six monthly or as directed by Infection Prevention and Control department or if they are visibly soiled or torn	Change twice per year and immediately if visibly soiled
Low risk Rehabilitation Office based practices	Change annually or if they are visibly soiled or torn	Change annually and immediately if visibly soiled

5.4 Changing disposable curtains

5.4.1 Ensure this is only attended to one side only so that date remains on the curtain .

5.4.1.1 Hand hygiene using ABHR or soap and water

5.4.1.2 Unhook curtains .

5.4.1.3 Hold them away from the body; do not throw onto the floor .

5.4.1.4 Dispose of used curtains by carefully folding and placing into



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a large plastic bag .

5.4.1.5 Curtains not contaminated with blood or body fluids can be disposed as general waste. Check manufacturer's instructions as items may be recyclable .

5.4.1.6 Curtains contaminated with blood or body fluids to be disposed as clinical waste .

5.5 Disposal of Antimicrobial curtains

5.5.1 Check manufacturer's instructions to determine if recyclable .

5.5.2 Dispose curtain into clear plastic bag and inform cleaning staff that curtains require transfer to recycling bin .

5.5.3 In the event that curtains are replaced throughout the ward. Prior notice to the cleaning supervisor /cleaner on duty should be given

5.6 Reusable curtains:

5.6.1 A schedule for routinely changing reusable curtains is to be developed that is based on area and clinical risk category .

5.6.2 Curtains to be stored as per linen policies .

5.6.3 Washing and drying of reusable curtains to comply Laundry Practices.

5.7 DOCUMENTATION

5.7.1 Ensure a date is on the curtain.

6. ATTACHMENT

6.1 Compliance Audit

7. REFERENCES

7.1 Health South Eastern Sydney Local Health District



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8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
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Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021

Compliance Audit For Curtains

Date:

Clinical Area:

Name of Auditor:

Annual Audit ☐ 6 month audit ☐ Random audit ☐

Any issues identified regarding the disposable curtains eg patient complaints

No.	Room/Bed number	Date last changed	Any sign of visible staining (y/n)	Any damage to curtain (y/n)	Comments
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

INTERDEPARTMENTAL POLICY PROCEDURE			
IPP VERSION:1	POLICY NUMBER:	APP: IPC-060	APPLIES TO: Infection Control, Environmental Health
	TITLE:	PEST CONTROL	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE :AUG 30,2021
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1.0. PURPOSE:

- 1.1. To present guidelines for coordinated efforts in addressing and controlling pest-related issues that are hazardous to the environment and the workplace.

2.0. DEFINITION:

- 2.1. **Pest Control** - refers to the regulation or management of a species defined as a pest, and can be perceived to be detrimental to a person's health, the ecology or the economy.

3.0. POLICY:

- 3.1. Cockroaches, flies, ants, mosquitoes, mites, mice, rats, lizards, pigeons, stray cats and dogs, and occasionally, snakes are pests that may constitute a nuisance or an infestation in healthcare facilities. Pests are agents or vectors for the mechanical transmission of disease causing microorganisms.
- 3.2. Insect habitats are characterized by warmth, moisture, and availability of food. Insects forage and feed on substrates, including but not limited to food scraps from kitchens, food from vending machines, discharges on dressings, other forms of human detritus, medical wastes, human wastes, and routine solid waste.
- 3.3. The direct association of insects with disease transmission (apart from vector transmission) is small. However, prevention efforts are recommended.
- 3.4. Modern approaches to institutional pest management usually focus on:
- 3.4.1. Eliminating food sources, indoor habitats, and other conditions that attract pests.
- 3.4.2. Excluding pests from the indoor environments.
- 3.4.3. Applying pesticides as needed.
- 3.5. Pigeons can also cause serious health effects and diseases. Recommended ways to contain issues of pigeon nuisances especially in housing facilities are as follow:
- 3.5.1. Remove the AC units from outside to inside the housing units to prevent nesting activities.



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- 3.5.2. Remove the decorative brown balconies to avoid the presence of pigeons around housing unit.
- 3.5.3. Use electrical shock on rooftops of each housing building to scare the pigeons.
- 3.5.4. Use available pharmaceutical anesthetic seeds such as 98% Alpha-Chloralose powder.
- 3.5.5. Implement an effective maintenance program on a regular basis to clean all traces of pigeon excretions in healthcare and housing facilities.

3.6. Three human diseases are known to be associated with pigeon droppings: Histoplasmosis, Cryptococcosis, and Psittacosis. Organophosphate affects the nervous system by reducing the ability of an enzyme called cholinesterase to function properly in regulating a neurotransmitter called acetylcholine. Acetylcholine helps transfer nerve impulses from a nerve cell to a muscle cell or another nerve cell. If acetylcholine is not properly controlled by cholinesterase, the nerve impulses or neurons remain active longer than they should, over stimulating the nerves and muscles and causing symptoms such as weakness or paralysis of the muscles. (See **Table 1 Pesticides** and **Table 2 Banned Pesticides**).

4.0. RESPONSIBILITY:

- 4.1. It is the responsibility of the staff to inform Infection Control and Public Health if they notice insects in their department.

5.0. PROCEDURE:

5.1. Responsibility

- 5.1.1. IP&C's Environmental Health personnel will:

- 5.1.1.1. Perform pre-sampling walk-through assessment and documentation of findings utilizing the appropriate forms.
- 5.1.1.2. Perform fungal sampling using the biological air sampler (e.g., Biotest RCS Centrifugal Air Sampler) or any other instrument deemed appropriate by the department.



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- 5.1.2. Engineering Services or any related engineering party will:
- 5.1.2.1. Complete the air sampling request form to be sent to IP&C.
 - 5.1.2.2. Advise IP&C of upcoming construction or maintenance projects.
 - 5.1.2.3. Advise IP&C of dates of specific construction and demolition phases to allow timely ordering of air sampling.
 - 5.1.2.4. Check HVAC, complete air balancing, make sure that no other engineering work is required to complete before requesting air sampling.
- 5.1.3. Internal Audit and Organizational Development is responsible for monitoring compliance to the provisions stipulated herein.

5.2. Acceptable Range of Air Samples

- 5.2.1. Aerobic cultures should not exceed 10 fungal colony forming units per cubic meter (CFU/m³) and not ≥ 2 CFU/M³ of A. Fumigatus in any patient care area.
- 5.2.2. For areas of high risk patients (e.g., hematology/oncology and liver or bone marrow transplant), aerobic cultures should have no fungal growth.

5.3. Equipment for Sampling

- 5.3.1. Biotest RCS Centrifugal Air Sampler uses fungal media strip (SDX agar), or any other approved device. An unopened "control" strip should be included with each sampling.
- 5.3.2. If the centrifugal sampling device is not available, air sampling may be conducted using settling plates with an appropriately selected media which may be obtained from Microbiology Laboratory.

6.0. MATERIAL/EQUIPMENT:

- 6.1. N/A

7.0. REFERENCE:

- 7.1. GCC Manual for Infection Control 3rd Edition Manual(2018)



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	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



TABLE 1: PESTICIDES

Organophosphate Pesticides	
Acephate	Mevinphos
Azinphos-methyl	Monocrotophos
Bensulide	Naled
Cadusafos Oxydemeton methyl	Oxydemeton methyl
Chlorethoxyfos	Phorate
Chlorpyrifos	Phosalone
Chlorpyrifos methyl	Phosmet
Chlorthiophos	Phosphamidon
Coumaphos	Phostebupirim
Dialiflor	Pirimiphos methyl
Diazinon	Profenofos
Dichlorvos (DDVP)	Propetamphos
Dicrotophos	Sulfotepp
Dimethoate	Sulprofos
Dioxathion**	Temephos
Disulfoton	Terbufos
Ethion	Tetrachlorvinphos
Ethoprop	Tribufos (DEF)
Ethyl parathion	Trichlorfon
Fenamiphos	
Fenitrothion	
Fenthion	
Fonofos	
Isazophos methyl	
Isofenphos	
Malathion	
Methamidophos	
Methidathion	
Methyl parathion	

TABLE 2: BANNED PESTICIDES

#	Common Name of Active Ingredient	Oral LD 50 (Rats)		Use	Reason for Banning
		Class	mg a.i./kg. Body wt		
1	Aldrin	Class I	38-67	Insecticide	High acute mammalian toxicity, persistence in the environment, possible human carcinogen.
2	BHC, HCH (1,2,3,4,5,6-Hexachlorocyclohexane)	Class II	-	Insecticide	Carcinogenic to animals, persistence and bioaccumulation, adverse environmental effects.
3	Camphochlor	Class I	69	Insecticide	Risks for human and animal health and the environment, long persistence and bioaccumulation.
4	Carbofuran	Class I, II	8	Soil Insecticide Nematicide	Acute inhalation toxicity, only liquid formulation to be banned.
5	Chlordane	Class II	367-515	Termiticide	Carcinogenic to rodents, persistence and bioaccumulation in the environmental.
6	Chlodrecone	Class II	114-140	Insecticide	Carcinogenic to rodents, persistence and bioaccumulation in the environmental.
7	DDT (Dichloro-Diphey trichloroethane)	Class III	113	Insecticide	Accumulation in humans, probably carcinogenic, persistence in the environment.
8	Demetion-O + Demetion-S	Class I	2.5-6	Systemic Insecticide	High acute toxicity for man and animals.
9	Demetion-S-methyl	Class I	30	Systemic Insecticide	High acute toxicity for man and animals.
10	Dichlorovos	Class I	50	Insecticide	Not acceptable in public health formulations for use inside houses and other structures because of its probable carcinogenic and mutagenic effect, may only be used in small

					percentages in tablets or strips for insect pheromone traps.
11	Dieldrin	Class I	37-87	Insecticide	Persistence in the environmental.
12	Disulfoton	Class I	4	Sys. Insect/ Acaricide	High acute toxicity.
13	Endosulfan	Class I	22.7-160	Insecticide	High acute toxicity, high persistence and potential for bioaccumulation.
14	Endrin	Class I	7-15	Insecticide	High acute toxicity, Central Nervous System Depressant and hepatotoxin, no antidote.
15	Ethyl Pyrophosphate (TEPP)	Class I	1.2-2	Insecticide	Very high acute toxicity to man ns animal, quickly absorbed through the skin, its vapors highly toxic.
16	Flueythrinate	Class I	67	Insecticide	Causes damage to the eye, very toxic by oral route and absorption through the skin, harmful if inhaled, causes carcinogenic effects to humans.
17	Gamma HCH	Class II	88- 125	Insecticide	Persistence in the environment, Bioaccumulation in food and the human body, probably carcinogenic to man and there is evidence that it encourages the growth of tumors caused by other factors.
18	Heptachlor	Class II	147-220	Termiticide	Carcinogenic to rodents, persistence and environment contamination.

19	Kelevan	-	-	Insecticide	Superseded
20	Leptophos	Class II	52.8	Insecticide	High acute toxicity, delayed neurotoxicity to humans and to laboratory animals.
21	Methamidophos	Class I	30	Insecticide	Highly toxic to mammals, there could always be health problems in misuse.
22	Methomyl	Class I	17-24	Insecticide	Highly toxic to man and animals, all formulations to be banned.
23	Methoxychlor	Class IV	6000	Insecticide	Long residual action (long persistence), bioaccumulation.
24	Mevinphos	Class I	3-12	Systemic Insecticide	Poisonous if swallowed, inhaled or absorbed through the skin
25	Mirex	Class II	306	Insecticide	Persistence and bioaccumulation in food, superseded.
26	Monocrotophos	Class I	14	Systemic Insecticide	High acute toxicity by oral, dermal and inhalation routes causing life threatening symptoms.
27	Oxamyl	Class I	5.4	Soil Insecticide/ Nematicide	Very high acute oral toxicity.
28	Oxydemeton-methyl	Class I	65-80	Systemic Insecticide	Highly toxic to man and animals.
29	Oxydeprofos	Class II	100	Systemic Insecticide	Highly toxic to man and animals.
30	Parathion	Class I	6	Insecticide	High acute toxicity by oral, dermal and inhalation routes causing life threatening symptoms, classified as class C carcinogen.
31	Parathion-methyl	Class I	6	Insecticide	Very high acute toxicity.
32	Phosphamidon	Class I	17-30	Systemic Insecticide	Poisonous if swallowed, inhaled or absorbed through the skin.

33	Schradan	-	-	Systemic Insecticide	Poisonous if swallowed, inhaled or absorbed through the skin superseded.
34	Sodium Floride	Class II	180	Insecticide	Very toxic to mammals and highly phytotoxic, used in insect baits and for timber preservation.
35	Strobane	Class II	220	Insecticide	Carcinogenic risk for humans, discontinued by manufacturing company.
36	Telodrin	-	-	Insecticide	Superseded
37	Chlordimeform	Class II	340	Acaricide	Probably human carcinogen.
38	Chlorobenzilate	Class III	2.784-3.880	Acaricide	A risk of cancer to human's males
39	Cyhexaine	Class III	540	Acaricide	Tetratogenic effects in mammals.
40	Dicofol	Class II, III	570-595	Acaricide	Potential bioaccumulation combined with persistence in the environment, may contain DDT as a contaminant (in the manufacturing process).
41	Benomyl	Class IV	10.000	Systemic fungicide	Evidence of genetic disturbances and fetal defects, increase of tumor growth formed in laboratory mice by other factors.
42	Captafol	Class IV	5000- 6000	Fungicide	Probably carcinogenic to humans.
43	Chlorothalonil	Class I, II	10.000	Fungicide	Chronic administration has been associated with tumor formation in the kidney and fore stomach of laboratory rats and mice.
44	Hexachlorobenzene (HCB)	Class IV	40.000 (seed dressing)	Fungicide	Carcinogenic to laboratory animals, persistence and bioaccumulation. month.
45	Mancozeb	Class IV	5000	Fungicide	At high levels may cause birth defects in test animals, a trace contaminant and a

					degradation product (ethylenethiourea) causes thyroid effects, tumors and birth defects in laboratory animals, moreover, this fungicide has long withholding periods of about one.
46	Maneb	Class IV	7990	Fungicide	At high levels may cause birth defects in test animals, a trace contaminant and a degradation product (ethylenethiourea) causes thyroeffects, tumors and birth defects in laboratory animals.
47	Mercury Compounds (e.g. Phenyl mercury acetate)	Class I	50-100	Fungicide & Herbicide	High acute toxicity, accumulation of residues in aquatic foods.
48	Thiram	Class III	1000	Fungicide	Combination of several severe chronic toxicity effects.
49	Zineb	Class IV	-	Fungicide	At high levels may cause birth defects in test animals, a trace contaminant and a degradation Product (ethylenethiourea) causes thyroeffects, tumors and birth defects in laboratory animals.
50	Ziram	Class I	1000	Fungicide	Combination of several severe chronic toxicity effects.
51	Amitrole, Aminotripole	Class III	5000	Herbicide	Risk of carcinogenic effects in humans.
52	Atrazine	Class III	1869-3080	Herbicide	Possible carcinogenic effects in humans.
53	Cyanazine	Class II	182-380	Herbicide	Possible carcinogenic effects in humans.
54	Dinoseb	Class I	40-60	Herbicide	High acute toxicity, teratogenic and carcinogenic effects, many cause sterility to human males.

55	Dinoseb Salts (e.g. Dinoseb Acetate)	Class I	40-60	Herbicide	High acute toxicity, teratogenic and carcinogenic effects, many cause sterility to human males.
56	Nitrofen	Class III	2630	Herbicide	Risks of mutagenic, teratogenic and carcinogenic effects.
57	Paraquat	Class II	150	Herbicide	High acute toxicity, no antidote.
58	Simazine	Class IV	5000	Herbicide	Possible carcinogenic effects to humans.
59	2,4,5-T (2,4,5-trichlorophenoxy acetic acid)	Class III	500	Herbicide	Possible teratogenic, carcinogenic effects to humans, long persistence and bio-accumulation
60	Arsenic Compounds	-	-	Rodenticide	High acute toxicity, exceptions are the organic arsenicals, which are of low toxicity, used as selective herbicides.
61	Fluoroacetamide	Class I	15	Rodenticide	High acute toxicity to man and other animals.
62	Sodium Fluoroacetate	Class I	0.22	Rodenticide	Odorless, tasteless and fast acting, chiefly in the heart. Discontinued by the manufacturing company.
63	Thallium Sulfate	Class I	16	Rodenticide	High acute toxicity, slow-acting cumulative poison.
64	Zinc Phosphide	Class I	45.7	Rodenticide	High acute toxicity in all handling operations.
65	Aldicarb	Class I	1	Sys.Insecticide / Nematocide	High acute toxicity.
66	Chloropicrin	Class I	250		Highly toxic by inhalation, and toxic by ingestion, can injury to the heart.
67	Dibromochloropropane (DBCP)	Class I	17-300	Soil Sterilant	May cause sterility to human males.
68	Ethylene dibromide (EDB)	Class I	146	Soil Sterilant	Potential carcinogen to humans may cause sterility to males,

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					persistence in ground water.
69	Pentachlorophenol (PCP)	Class I	50-500		Adverse liver and kidney effects, possible carcinogenic to humans.



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1. PURPOSE

- 1.1. To monitor the quality of water by defining the essential quality standards for water consumption at any healthcare facility; minimize microbial contamination of any water related health risk for patients, staff, and their community; and, meet the quality requirements of the Ministry of Health.

2. DEFENTION

N/A

3. RESPONSIBILITIES

- 3.1. All hospital staff

4. POLICY

- 4.1. Potable drinking water compliant with quality standards must be maintained at healthcare facilities to protect patients, staff, visitors, and the whole community. These standards must be strictly enforced to limit contamination and avoid health hazards.
- 4.2. A regular microbiological sampling and testing from all water supply areas must be conducted by the Infection Prevention and Control (IP&C) Department.
- 4.3. Immediate corrective action shall be taken as recommended by the IP&C for any potential water contamination or infection risk in coordination with concerned departments such as Facility Management & Safety (Utilities & Maintenance U&M section).
- 4.4. Laboratory facilities shall perform the required analysis for any urgent or corrective measure of routine water analysis to maintain acceptable water quality.
- 4.5. Records of laboratory results related to water quality monitoring shall be maintained by IP&C, Facility Management & Safety (U&M section), and other concerned departments.
- 4.6. An effective preventive program which includes treatment such as chlorination and chlorine monitoring, cleaning water supply system, and sampling schedule will be designed and implemented.
- 4.7. All efforts shall be made to prevent risk of contamination of water supply system due to chemicals used, renovation and construction, fire, or other related industrial, agricultural, and human activities.

5. PROCEDURE

- 5.1. Routine maintenance program to maintain an acceptable clean water distribution system.
- 5.2. U&M will properly manage the chemical water treatment to ensure safe drinking water.
- 5.3. U&M must ensure sufficient water available in the hospital.



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- 5.4. Chlorination systems, TDS and PH will be checked daily by U&M to ensure the chlorination compound supply has not run out and applicable limits are respected.
- 5.5. The Water Distribution Management Plan:
- 5.5.1. **Preventive measures.** A preventive maintenance program will include monitoring, inspection, cleaning, disinfection of the water supply system, sampling schedules, and frequency of the following listed below:
- 5.5.1.1. Potable water system.
- 5.5.1.2. Dental clinic
- 5.5.2. **Testing equipment and water sampling.**
- 5.5.2.1. A detailed physico-chemical potable water quality testing and sampling will be performed semi-annually by an independent certified water-testing laboratory. A copy of the results must be forwarded to IP&C.
- 5.5.2.2. Water quality testing for dental water shall be performed for microbiological parameters as described in Table IPC50-01 (AAMI and EPA Maximum Allowable Levels of Contaminants in Water) at least semi-annually. A copy of the results must be forwarded to IP&C and dental department.
- 5.5.3. **Record keeping :**
- 5.5.3.1. Records of water quality sampling results, laboratory reports, and chemicals used for treatment must be available at all times and be retained for a period of five years.
- 5.5.4. **Physical Parameters**
- 5.5.4.1. The water shall be aesthetically acceptable to consumers. Unusual taste and color might be an indication of potential contamination. However, the maximum allowable levels of contaminants in water are as follows:
- 5.5.4.1.1. Color <15 TCU (True Color Unit).
- 5.5.4.1.2. TDS < 600 mg/L (Total Dissolved Solids)
- 5.5.4.1.3. Turbidity < 5 NTU (Nephelometric Turbidity Units).
- 5.5.4.1.4. Ph:6.5-8.5
- 5.5.4.1.5. Total hardness: Mg/I as CaCo, Max 200
- 5.5.4.2. See Table IPC61-1 for microbiological and chemical parameters.
- 5.6. Water Sampling : Water sampling must be conducted in accordance with the following steps:
- 5.6.1. Flush the tap for at least one minute. If the tap is a mixing faucet, attachments (i.e. screen and aerators) must be removed. Hot and then cold water must be allowed to



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run through the tap for at least 1-10 minutes based on the location and frequency of use.

- 5.6.2. Turn off the tap and disinfect the end of the tap by 70% isopropyl alcohol or by using 500-600 ppm chlorine sodium hypochlorite (1:100 v/v dilution of chlorine bleach).
- 5.6.3. Turn on the tap and let it run for a few seconds before taking the sample.
- 5.6.4. Samples shall be collected in a sterile bag of minimum 100 ml capacity.
- 5.6.5. A reducing agent called Sodium Thiosulphate [Na₂S₂O₃] shall be added to neutralize residual chlorine and other halogens in the sample.
- 5.6.6. If the water contains elevated levels of heavy metals, then a chelating agent shall be added to the specimen.
- 5.6.7. Sample site, date, and time shall be written on the label of each sample.
- 5.6.8. Water samples must be kept in cold (approximately 4oC) containers and sent immediately to the designated laboratory preferably within 24 hours.
- 5.6.9. Usage of sterile reduced nutrient media (e.g., diluted peptone and R2A) is preferable with either of the techniques such as heterotrophic plate count, pour plate, spread plate or member filtration.
- 5.6.10. Incubation temperatures will be closer to the temperature of the water rather than at 35oC within 24 hours for total coliform; and 44.5oC for fecal coliform within 48 hours.
- 5.7. Emergency Water Use and Other Water System.
 - 5.7.1. Safety shower and eye wash stations shall be flushed weekly by the department or as per agreement with Fire Protection Services.
 - 5.7.2. The hot water temperature shall be maintained in accordance with the American Institute of Architect's (AIA) guidelines. Water temperature shall be maintained in patient care areas within the range of 105 - 120oF (40 - 49°C).
- 5.8. Corrective and Remedial Action
 - 5.8.1. Any complaint of contamination shall necessitate complete investigation and immediate appropriate corrective action by the IP&C, U&M, and concerned departments.
 - 5.8.2. A corrective action plan in response to various disease outbreaks or water contamination incidents should be in place.
 - 5.8.3. On completion of corrective actions, water resampling tests will be performed to ensure successful elimination of contamination. The reporting department will be notified to confirm water source is released for use as per the water resample results and release form.



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5.8.4. The following steps shall be taken into consideration to minimize potential exposure risk:

5.8.4.1.1. Management of working hours by scheduling preventive maintenance during periods of low occupancy.

5.8.4.1.2. Isolate work area using temporary barriers.

5.8.4.1.3. Implement the use of specialized cleaning products, disinfectants, and procedures.

5.9. Chemical Use

5.9.1. U&M will make sure that only IP&C approved chemicals are used in water treatment programs.

5.9.2. Updated Safety Data Sheets (SDS) and chemical inventories for chemicals added to water will be maintained.

6. ATTACMENT

6.1 Table IPC061-01: AAMI and EPA Maximum Allowable Levels of Contaminants in Water

6.2 Table IPC061-2 :Water Contamination Reporting Form

6.3 Table IPC061-3:Water Resample Results and Release Form



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Table IPC50-01:
AAMI and EPA Maximum Allowable Levels of Contaminants in Water

MNGHA Microbiological Standards for Drinking and Hemodialysis Water		
Contaminant	Drinking Water	Hemodialysis Water
E. Coli	0	0
Coliform	0	0
Enterococci	0	0
Legionellae	0	0
Virus	0	0
Other Bacteria:		
HPC	≤500 cfu/ml	≤100 cfu/ml
Action Level	≥200 cfu/ml	≥50 cfu/ml
Endotoxin:		
Acceptable Maximum Level (EU/ML)	N/A	0.25
Action Level (EU/ML)	N/A	0.125
** Action level at 90 th percentile		HPC – Heterotrophic Plate Count CFU – Colony Forming Units
Source: 1. Association for the Advancement of Medical Instrumentation (AAMI). (2015). Water Quality for Dialysis. 2. World Health Organization, Geneva (2014). Guidelines for Drinking Water Quality – Recommendations. (4 th ed., vol. 1).		



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Table IPC061-2:
Water Contamination Reporting Form

Reference #: _____

Date: _____

To : _____

Director of
Utilities and Maintenance

Water Contamination Description:

Location	Microbial Growth cfu/ml	Chlorine Level	Chloramine Level	Endotoxin	Physical Parameter: Color or elements traces

Recommendation / Corrective Action:

Inspected and Sample Taken by:

Name & Signature from IP & C Department

Reviewed and Approved by:

(Director's Name & Signature IP&C Department)



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Table IPC061-3:
Water Resample Results and Release Form

To: _____
Requesting Department

Date: _____

Water Resample Results:

Location	Microbial Growth cfu/ml	Chlorine Level	Chloramine Level	Endotoxin	Physical Parameter: Color or elements traces

Remark:

Inspected and Sample Taken by:

Name & Signature from IP & C Department

Reviewed and Approved by:

(Director's Name & Signature IP&C Department)



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7. REFERENCES

7.1. GCC Infection Prevention and Control 3rd Edition Manual (2018)

8. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		1-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Mansor Rajhi	FMS Director		8-7-2021
	Mr. Hadi Awaji	E.H supervisor		8-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms.Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021





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1.0. PURPOSE:

- 1.1. To provide guidelines on the Appropriate use and Decontaminated all Telemedicine Tablets and accessories.
- 1.2. To Proper Management of all Telemedicine Tablets and accessories.

2.0. DEFINITIONS:

- 2.1. Decontamination: the use of physical or Chemical methods to remove, inactivates, or Destroy microorganisms, rendering them for Safe handling
- 2.2. .Disinfection: the elimination of pathogens And disease-causing microorganisms, except Bacterial spores.Cleaning: the removal of visible soil•Debris, microorganisms and organic Substances from surfaces; will not eliminate Gems but reduces their numbers by Removing some contaminated matter

3.0. RESPONSIBILITIES:

- 3.1. All Telemedicine Staff :it is the responsibility of all clinical staff Participating in all area use telemedicine Services to maintain, the cleanliness and Disinfect all the tablets and their Accessories in a regular schedule or Every after used
- 3.2. Hospitals' IPC :Ensure the implementation of this Policy.

4.0. .POLICY:

- 4.1. Patient Care Items Must Be Decontaminated according to the Categories involved or according to Manufacturer's recommendation.
- 4.2. Standard precautions must be followed When handling contaminated items
- 4.3. Used only MOH approved disinfectant when cleaning and disinfection of the Machine
- 4.4. Appropriate PPE is used during their Cleaning activities. Mask, gown and Gloves are recommended.



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4.5. Cleaning schedule and checklist must be Used and document them regularly by The responsible staff.

4.6. Make sure all devices and accessories Are powered off before cleaning.

4.7. Refer to the specific manual for each Specific machine

5.0. PROCEDURE:

5.1. General Cleaning Guidelines

5.1.1. Examine the protective cover, accessories, Power cables, adapters, and carrying case For any damage or tear. Replace if Necessary.

5.1.2. Gently wipe all items as needed with a lint-Free microfiber cloth dampened with a Small amount of distilled water.

5.1.3. Avoid getting excess moisture onto the Devices; the corner of the microfiber cloth Is sufficient

5.1.4. You may also use a camera lens cleaning Cloth.

5.1.5. Do not apply too much pressure on the Devices.

5.1.6. Do not use household cleaners or Housekeeping as they may damage the Devices.

5.1.7. Do not use compressed air, as it may Damage the devices

5.2. Disinfecting Guidelines

5.2.1. Gently wipe all items using a disinfectant Such as a hypochlorous acid-based solution Containing 50-80ppm (such as Clorox or Lysol disinfectant wipes), or an alcohol- Based solution containing more than 70% Ethanol or isopropyl alcohol..

5.2.2. Do not apply these liquid solutions directly To any item; they should be carefully Applied with a pre-moistened wipe or by Dampening the corner of a microfiber cloth With a small amount of the disinfectant.

5.3. Disinfecting Equipment



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5.3.1. Remove all contents from the carrying case. Remove the TABLET (IDM-100) from the Protective cover.

5.3.2. Cables and Adapters: Inspect all power cables and adapters

5.3.2.1. For dirt and foreign debris. Wipe Connectors and entire length of cable Disinfecting According to the Guidelines above.

5.3.3. For machine TABLET (IDM-100):

5.3.3.1. Wipe the tablet on all sides according To the Disinfecting Guidelines above.

5.3.3.2. Inspect the device front, back, ports And buttons for any foreign debris.

5.3.4. Blood Pressure Monitor:

5.3.4.1. Wipe the monitor on all sides According to the Disinfecting Guidelines above. Inspect the device Front, back, and all sides, ports and Buttons for any foreign debris. Wipe The cuff, hoses, and connectors According the Disinfecting Guidelines Above

5.3.4.2. inspect the hoses and connectors for Any foreign debris. Inspect the cuff Velcro for foreign debris. Make sure The area where the hose connects to the Cuff is unbroken.

5.3.5. SpO2 Sensor:

5.3.5.1. Wipe the SpO2 sensor on all sides and Inside the finger opening according to The Disinfecting Guidelines above.

5.3.5.2. Be sure to reach the hinge area inside. Inspect the device front, back, and all Sides, joints, and crevices for any Foreign debris

5.3.6. Thermometer:

5.3.6.1. If still attached, eject and dispose of The probe cover. Throw away all Unused probe cover S into infectious Yellow waste bin.



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5.3.6.2. Wipe the thermometer and base on all Sides and around the probe area According To the Disinfecting Guidelines above. Inspect the front, Back, and all sides, joints, and crevices For any foreign debris.

5.3.7. Scale:

5.3.7.1. Wipe the scale on all sides according To the Disinfecting Guidelines above, Paying attention to crevices and Cracks.

5.3.7.2. Inspect the device front, back, and all Sides, joints, and crevices for any Foreign debris.

5.3.8. Glucometer

5.3.8.1. We do not recommend using this Accessory for more than one patient, But if necessary, wipe the meter on all Sides according to the Disinfecting Guidelines above.

5.3.8.2. Inspect the meter on all sides, ports And buttons for any foreign debris.

5.3.8.3. Remove the plunger cover and Carefully discard the lancet.

5.3.9. Stethoscope and Headphones:

5.3.9.1. .wipe all parts and the entire length of Cable according to the Disinfecting Guidelines above.

5.3.10. ECG Machine:

5.3.10.1. Wipe the tablet on all sides according To the Disinfecting Guidelines above.

5.3.10.2. Wipe the monitor on all sides According to the Disinfecting Guidelines above. Inspect the device Front, back, and all sides, ports and Buttons for any foreign debris.

5.3.10.3. ECG leads must be single used, and Discard properly into infectious yellow Waste bin.



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5.3.10.4. ECG bulb must be washed with Running water and rinse properly, and Keep it dry. Make sure the gel is Properly removed

5.3.10.5. Disinfect with alcohol wipes before Reusing.

5.3.11. Carrying Case: Remove dividers.

5.3.11.1. Clean all Surfaces with a mild cleaning solution. Inspect all sides, joints, and crevices for any Foreign debris. Wipe down according to the Disinfecting Guidelines above.

5.3.12. Protective Cover of the TABLET (IDM -100) machine, clean all surfaces and around The comer clips with a mild cleaning Solution. Inspect all sides, joints, and Crevices for any foreign debris. Wipe down According to the Disinfecting Guidelines Above

6.0. .FORMS:

6.1. Cleaning Schedule

7.0. REFERENCES

7.1. GCC Manual for Infection Control 3d Edition Manual (2018)

7.2. Cleaning and Disinfecting the TABLET (IDM-100) and Accessories
www.dictumhealth.com Last Modified: September 8, 2020 9:51 AM 870-00063-01 Rev B



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DEPARTMENT OF INFECTION PREVENTION AND CONTROL

DEPARTEMNTAL POLICY PROCEDURE			
DPP VERSION:1	POLICY NUMBER:	DPP: IPC-062	APPLIES TO: HOSPITAL WIDE
	TITLE:	MANAGEMENT AND DECONTAMINATION TELMEDICINE MACHINE	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:6 of 6

8.0. APPROVAL

	NAME	POSITION	SIGNATURE	DATE
Prepared by:	Mr. Ali Neshili	IPC coordinator		17-7-2021
Reviewed by:	Mr. Ali Neshili	IPC Director		3-7-2021
	Mr. Fahd najmi	Nursing Director		8-7-2021
	Ms. Bander Mohnshi	BioMed Supervisor		9-7-2021
Concurred	Dr. Shwagy Alhazmi	IPC committee chairman		13-7-2021
	Ms. Aisha Khubrani	Quality Director		13-7-2021
Approved by:	Dr. Shwagy Alhazmi	Medical Director		26-7-2021
	Mr. Khalid Al-Harthi	Hospital Director		26-7-2021



AL-HARTH GENERAL HOSPITAL

Department of Infection Prevention and Control

Cleaning Check List of telemedicine Equipment and accessories, tablet in Patient Care Area

Department:	Month: 2021	IPC CHECKER:
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CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTEMENTAL POLICY PROCEDURE			
DPP VERSION:2	POLICY NUMBER:	DPP-CSSD-01	APPLIES TO:HOSPITAL WIDE
	TITLE:	DISINFECTION AND STERILIZATION OF SURGICAL/DENTAL INSTRUMENTS	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 3

1.0 PURPOSE:

- 1.1.To keep supplies and equipment safe, sanitary and in good working condition as necessary for the dental services performed by dental clinic staff.
- 1.2.To ensure the safety of patients and staff from contaminates caused by infectious and hazardous waste.

2.0 DEFINITIONS:

- 1.3.To outline the process of assessment, approval, proper disinfection and reprocessing of surgical instruments used in the dental clinic.

3.0 Responsibility:

- 3.1 Policy is applied to all CSSD personnel and dental clinic.

4.0 POLICY

- 4.1.All personnel that are assigned or engaged in sterile service operation and dental clinic.

5.0 PROCEDURE:

- 5.1.The dental clinic nurse must process the dental fillings by immersing them in a container containing the cleaning solution and removing the residue of the fillings as a preliminary treatment before sending them to the sterilization department.
- 5.2.Surgical instruments containing blood and tissue residue with pre-cleans and sent to the sterilization department.
- 5.3.Surgical instruments should be sent in a tightly closed container or in a closed carts to prevent the spread of infection.
- 5.4.Single use disposable items will be discarded.



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CENTRAL STERILIZATION SUPPLY DEPARTMENT

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5.5.Sterilized materials will be packaged and labeled to assure sterility.

6.0 ATTACHEMENT:

6.1 NIL

7.0 REFERANCE:

- 7.1. Association for the Advancement of Medical Instrumentation Advanced AAMI 2011,
The International Association of Healthcare Central Service Materiel Management
IAHCSMM 7th Edition, CDC Disinfection, and sterilization Guidelines 2009. AORN
Recommended Practices XI, XII.



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CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTEMENTAL POLICY PROCEDURE			
DPP VERSION:2	POLICY NUMBER:	DPP-CSSD-01	APPLIES TO:HOSPITAL WIDE
	TITLE:	DISINFECTION AND STERILIZATION OF SURGICAL/DENTAL INSTRUMENTS	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE: AUG 30,2021
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8.0 APPROVAL:

	NAME	DESIGNATION	SIGNATURE	DATE
Prepared by:	Ms. Mariam Sahly	CSSD Quality Coordinator		1-7-2021
Review by	Mr. Ali Hazazi	Head of CSSD		3-7-2021
	Dr. Ahmad Hamdi	Head Of Dental Clinic		8-7-2021
	Mr. Fahad Najmi	Nursing Director		9-7-2021
	Mr. Ali Neshili	IPC Director		9-7-2021
Concurred by:	Dr. shawgy alhazmi	P & P Committee Chairman		13-7-2021
	Ms. Aisha Khubrani	Quality & Patient Safety Director		13-7-2021
Approved by:	Dr. shawgy alhazmi	Medical Director		26-7-2021
	Mr. Khaled Harithi	Hospital Director		26-7-2021





CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTMENTAL POLICY & PROCEDURE			
DPP VERSION:2	POLICY NUMBER:	DPP-CSSD-019	APPLIES TO: CSSD PERSONNEL
	TITLE:	TRANSPORT OF SOILED ITEMS	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30.2021
	DUE FOR REVIEW:	JUL 30.2023	NUMBER OF PAGES:1 of 4

1. PURPOSE:

1.1.To outline the basic procedures for transportation of soiled and contaminated items from users to CSSD Decontamination area.

2. DEFINITIONS:

2.1.**Soiled items-** are the contaminated items used by the users.

3. RESPONSIBILITIES:

3.1.The following functions are performed by the CSSD staff

4. POLICY:

4.1.Personnel transporting contaminated items must consistently follow safe handling procedures .These include methods to safely load Transport devices to avoid spillage and to assure that items are securely contained.

5. PROCEDURE:

5.1.Contaminated items should be contained in closed carts before transport through the facility to minimize airborne or spread contact of microorganism and to reduce the risk of cross-contamination and infection.

5.2.The end user in the departments should Spry the soiled Instruments with transportation gel to keep it moist until starting the processing.



CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTMENTAL POLICY & PROCEDURE			
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- 5.3. Instruments from the departments /units which will be transported to CSSD in closed containers or carts used for transporting contaminated items should not be used to transport and deliver clean items.
- 5.4. Items from surgery should be transported to CSSD Decontamination area immediately after use. This reduces the opportunity for soiled instruments to dry.
- 5.5. The Departments representative who delivers the instrumentation for processing.
- 5.6. Checks in at the CSSD front desk / counter, where he or she presents the "Interdepartmental Request Form". The Front desk person checks to make sure the form has been filled out correctly and completely. He or she must also verify quantity and condition of the items. A sterile processing technician may have to assist in this process.
- 5.7. The CSSD employee will sign the "Interdepartmental Request form", give one copy to the department representative and forward the second copy along with the instrumentation. He or she will take the instrumentation to the decontamination area and notify the Sterile Processing staff and they should be handled according to approved guidelines.
- 5.8. CSSD staffs who transport contaminated items should wear a lab coat over their scrub suits. Gloves should be worn to handle contaminated items. The gloves should then be removed and hands should be washed.
- 5.9. CSSD staff should maintain control of their carts and pay particular attention to hall way and doors that may open into the path of the cart.
- 5.10. The "Interdepartmental Request Form" will accompany the instrumentation throughout the various stages of processing.
- 5.11. Whenever there is a danger of splash, spills, or aerosol exposure.



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5.12. Central service technician should wear appropriate personal protective equipment (PPE) required by Occupational Safety and Health Administration (OSHA) Regulations and the CSSD technician who assigned to clean and decontaminate should follow these regulations.

6. ATTACHMENT

6.1.NIL

7. REFERENCES:

7.1.Association for the Advancement of Medical Instrumentation Advanced AAMI 2011,
The International Association of Healthcare Central Service Materiel Management
IAHCSMM 7th Edition, CDC Disinfection and sterilization Guide lines 2009 .AORN
Recommended Practices XI, XII



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CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTMENTAL POLICY & PROCEDURE			
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8. APPROVAL:

	NAME	DESIGNATION	SIGNATURE	DATE
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Review by	Mr.Ali HAZAZI	Head of CSSD		3-7-2021
	Mr. Ali Neshili	IPC director		9-7-2021
Concurred by:	Dr.Shawgy Al-Hazmi	P & P Committee Chairman		13-7-2021
	Ms. Aisha khubrani	Quality & Patient Safety Director		13-7-2021
Approved by:	Dr.Shawgy Al-Hazmi	Medical Director		26-7-2021
	Mr.Khaled Harithi	Hospital Director		26-7-2021





CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTMENTAL POLICY & PROCEDURE			
DPP VERSION:2	POLICY NUMBER:	DPP-CSSD-004	APPLIES TO:CSSD PERSONNEL
	TITLE:	DISTRIBUTION OF STERILE ITEM	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
	DUE FOR REVIEW:	JUL 30,2023	NUMBER OF PAGES:1 of 3

1. PURPOSE:

1.1.To outline the basic procedures for transportation of sterile items from CSSD to Departments.

2. DEFINITIONS:

2.1.Sterile items- are the processed items and treated in the CSSD.

3. RESPONSIBILITIES:

3.1.The following procedures and tasks are performed by the CSSD staff and the users.

4. POLICY STATEMENT:

4.1.Personnel transporting sterile items must consistently follow safe handling procedures .These includes methods to assure that items are securely contained.

5. PROCEDURE:

5.1.The sterile item will be placed in a closed cart and staged in a designated pick-up area. The "Interdepartmental Request Form" will be taped to the outside of the plastic bag .Upon pick-up, the department representative will present his or her copy of the "Interdepartmental Request Form" to the Sterile Storage area front desk / counter person, who will retrieve the item from the pick-up area.

5.2.The Department representative should verify the quantity and condition of the item he or she is picking up, and if satisfied, sign the "Interdepartmental Request Form".



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	TITLE:	DISTRIBUTION OF STERILE ITEM	
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His signed copy will be retained at the front desk for six months, after which it may be discarded.

6. ATTACHMENT:

6.1 NIL

7. REFERENCES:

- 7.1. Association for the Advancement of Medical Instrumentation Advanced AAMI
2011, The International Association of Healthcare Central Service Materiel
Management IAHCSMM 7th Edition, CDC Disinfection and sterilization Guide
lines 2009 .AORN Recommended Practices XI, XII



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CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTMENTAL POLICY & PROCEDURE			
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8. APPROVAL:

	NAME	DESIGNATION	SIGNATURE	DATE
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	Mr. Ali Neshili	IPC director		9-7-2021
Concurred by:	Dr.Shawgy Al-Hazmi	P & P Committee Chairman		13-7-2021
	Ms. Aisha khubrani	Quality & Patient Safety Director		13-7-2021
Approved by:	Dr.Shawgy Al-Hazmi	Medical Director		26-7-2021
	Mr.Khaled Harithi	Hospital Director		26-7-2021





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CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTMENTAL POLICY & PROCEDURE		
DPP VERSION:2	POLICY NUMBER:	DPP-CSSD-012
	TITLE:	RECALL OF UNSTERILE ITEMS AND PREPARED SUPPLIES
	APPROVAL DATE:	JUL 30,2021
	DUE FOR REVIEW:	JUL 30,2023
		APPLIES TO:CSSD PERSONNEL
		EFFECTIVE DATE : AUG 30,2021
		NUMBER OF PAGES:1 of 6

1. PURPOSE:

1.1.To set a guideline on recall of sterilized items if sterilization or disinfection processes were found later to be deficient or failed.

2. DEFINATION:

2.1.NIL

3. RESPONSIBILITIES:

3.1.Infection Control and CSSD staff.

4. POLICY:

4.1.Positive biological indicator is a significant event. All medical devices processed in that specific sterilization unit since the last negative BI is considered non-sterile. It is of utmost importance to accurately assign lot numbers and record items to be sterilized within CSSD department because this is the record to be used to identify all items from affected cycles. Once all items have been identified they are to be located and retrieved. All must be completely reprocessed.

4.2.A second BI should be immediately processed while holding the suspect items in quarantine. If you would like to know if the BI was contaminated and human error caused the positive, the positive BI can be sent to the lab for identification of the specific microorganism. If it is different than the microorganism in the BI you have confirmed that the BI has been contaminated and the positive was caused by human error.



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DEPARTMENTAL POLICY & PROCEDURE			
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	TITLE:	RECALL OF UNSTERILE ITEMS AND PREPARED SUPPLIES	
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5. PROCEDURE:

5.1.Review the sterilization printout carefully to be sure there were no inaccuracies. Before beginning the recall process, look at the following carefully. These are all possible causes of a positive BI:

5.1.1. Was there inadequate sterilization time?

5.1.2. Was the exposure time set correctly for the temperature?

5.2.Review how the sets were prepared, packaged, labeled, and loaded into the sterilizer.

5.3.Was the test pack improperly processed?

5.4.Review the actual processes performed by the staff to determine if the positive was caused by the operator. 85% of most sterilization errors are caused by the operator.

5.5.Is it possible that the load was never started and the contents were never processed?

5.6.Was the correct BI used?

5.7.Was the control and the BI from the same lot?

5.8.Was the BI contaminated with microorganisms not originally in the BI?

5.9.Was the incubation faulty?

5.10. Recalls all items from cycles sterilized back to the last negative biological indicator results in the affected sterilizer are retrieved.

5.11. The first thing a staff member needs to do is notify the appropriate Supervisor or their designee of situations that may warrant a recall such as A positive biological indicator, a failed mechanical indicator, an Unacceptable Internal or external chemical indicator or any situation that Indicates that a load was not adequately processed.

5.12. The supervisor or designee would then make the decision to implement a recall based on the facilities policies and procedures. Recall procedures are established



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to expedite the retrieval of processed items that have been determined to be suspect, immediately quarantine the sterilizer and notify physicians or departments that may have received the suspect items.

5.13. Once a recall has been deemed necessary, notification of physicians and departments should be the beginning of the recall process and subsequent to needed documentation. The information used in the documentation could include but is not limited to: - Supervisor or designee initiating and or authorizing the recall.

5.13.1. The individual responsible for documenting the results of the recall

5.13.2. Reason for the recall

5.13.3. Time and date of the suspect cycle

5.13.4. Description of the load contents with reference given to the Lot and Load control numbers.

5.13.5. The results of the print out or graph depending on your sterilization unit.

5.14. When there is evidence of a sterilization failure the Infection Control Department should be notified to follow-up if any of the suspect medical devices were used on patients and consult with the physicians that came in contact with the suspect medical devices.

5.15. Notify your sterilizer service representative for assistance in determining the sterilization failure. The combined results of mechanical, chemical and biological monitoring should determine the success of any changes made or become obvious if the sterilizer continues to malfunction.

5.16. Once the cause has been noted, arrange to have the unit serviced or repaired. After the corrections have been made, a vacuum steam sterilizer must be



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revalidated with three consecutive negative biological monitors in three consecutive cycles, followed by three consecutive dynamic air removal tests. Each type of cycle (gravity and pre-vacuum) must be tested and all test results negative before the sterilizer is put back into use.

5.17. The unit is not to be used until the results of these tests are acceptable. Once the sterilizer is determined to be functioning properly it can be put back into routine use. It is important to keep records. This includes the time/date of the cycle, sterilizer identification, packaging materials, location of the BI, results of the test and the control; and the name of the person conducting and reading the test.

5.18. **Recall Procedure should**

5.18.1. Be written

5.18.2. Outline the circumstances for issuing a recall order designate the person(s) authorized to issue a recall order.

5.18.3. Designate the person(s) responsible for reporting on the execution of a Recall order.

5.19. **Recall Order should:**

5.19.1. Include all items processed back to the last negative BI

5.19.2. Be immediately communicated to affected departments and followed by a written order

5.19.3. Identify by sterilization lot number the products to be recalled

5.19.4. Identify the persons or departments to whom the order is addressed

5.19.5. Require the recording, in terms of kind and quantity, of the products obtained in the recall



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5.19.6. Specify the action to be taken by the persons receiving the order (e.g., destruction or return of the product)

5.20. **Recall Report should**

- 5.20.1. Identify the circumstances that prompted the recall order
- 5.20.2. Specify the corrective action(s) taken to prevent a recurrence
- 5.20.3. State, in terms of the total number of products intended to be recalled, the percentage of products actually located in the recall
- 5.20.4. Provide verification that the recalled items were reprocessed or destroyed, as appropriate.

6. FORMS / EQUIPMENT

6.1. Appendix 1 Recall Form

6.2. **IMPLEMENTATION PLAN:** the CSSD staff and individuals looking after medical instrumentation and devices in the hospitals and medical centers are those who will implement the plan according management compliance and approval.

7. REFERENCES:

- 7.1. Association for the Advancement of Medical Instrumentation Advanced AAMI 2011, The International Association of Healthcare Central Service Materiel Management IAHCSCMM 7th Edition, CDC Disinfection and sterilization Guide lines 2009 .AORN Recommended Practices XI, XII



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CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTMENTAL POLICY & PROCEDURE			
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8. APPROVAL:

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	Mr. Ali Neshili	IPC director		9-7-2021
Concurred by:	Dr.Shawgy Al-Hazmi	P & P Committee Chairman		13-7-2021
	Ms. Aisha khubrani	Quality & Patient Safety Director		13-7-2021
Approved by:	Dr.Shawgy Al-Hazmi	Medical Director		26-7-2021
	Mr.Khaled Harithi	Hospital Director		26-7-2021





CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTMENTAL POLICY & PROCEDURE			
DPP VERSION:2	POLICY NUMBER:	DPP-CSSD-013	APPLIES TO: CSSD PERSONNEL
	TITLE:	REGULAR MAINTENANCE FOR ALL CSSD EQUIPMENT	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
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1. PURPOSE:

- 1.1.To comply with the standard set to ensure a safe working environment within hospital mandated limits.

2. DEFINITIONS:

- 2.1.PPM-Periodical Preventative Maintenance

3. RESPONSIBILITIES:

- 3.1.The following functions are performed by the CSSD and Biomedical Engineer/technician

4. POLICY:

- 4.1.Document the process record, cycle performance and establish accurate and complete records required for process verification which are useful in malfunction analysis.

5. PROCEDURE:

- 5.1.Every morning, the assigned Biomed Engineer in coordination with the CSSD Supervisor and technician will check the steam sterilizers Main parameters: Temperatures, Steam Pressure, Compressed Air Pressure, Door Gasket (Leak test), Vacuum pump condition, Bowie Dick test result, Printer Condition.
- 5.2.The assigned Biomed Engineer in coordination with the CSSD Supervisor and technician will check the plasma sterilizers Main parameters: The expiration of cassette over all plasma sterilizer condition ,verification of print out function,



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5.3.Preventive Maintenance of the Plasma sterilizer should be done according the manufacturer recommendations.

5.4.For the instrument Washer Disinfector, the concern persons should check: Water supply condition, Arm sprinkler rotation, Drainage, Arm Door Lock.

5.5.Preventative Maintenance should be done according to the manufacturer recommendation for: Steam sterilizer, instruments sealer, instrument washer/disinfector, plasma sterilizer and drying cabinet.

5.6.Cleaning of all CSSD equipment should be done by the CSSD technician every weekend.

5.7.Daily monitoring and documentation done by the Biomed personnel should be filled in engineering affair with copy to CSSD Manager.

6. ATTACHMENT:

6.1 NIL

7. REFERENCES:

- 7.1.Association for the Advancement of Medical Instrumentation Advanced AAMI 2011,
The International Association of Healthcare Central Service Materiel Management
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8. APPROVAL:

	NAME	DESIGNATION	SIGNATURE	DATE
Prepared by:	Ms. Mariam Sahly	CSSD Quality Coordinator		1-7-2021
Review by	Mr.Ali HAZAZI	Head of CSSD		3-7-2021
	Mr. Ali Neshili	IPC director		9-7-2021
Concurred by:	Dr.Shawgy Al-Hazmi	P & P Committee Chairman		13-7-2021
	Ms. Aisha khubrani	Quality & Patient Safety Director		13-7-2021
Approved by:	Dr.Shawgy Al-Hazmi	Medical Director		26-7-2021
	Mr.Khaled Harithi	Hospital Director		26-7-2021





CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTMENTAL POLICY & PROCEDURE			
DPP VERSION:2	POLICY NUMBER:	DPP-CSSD-022	APPLIES TO:HOSPITAL WIDE
	TITLE:	Single Use Devices (SUD)	
	APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
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or disposable patient care item that has been cleaned, disinfected, or sterilized and then tested for functionality after its original use on a patient.

3.4. Reprocessing refers to the cleaning, disinfecting, repackaging, and sterilizing of an item that was either.

3.4.1. used on a patient or

3.4.2. not used on a patient but has its original packaging compromised.

Manufacturer's instructions now known as information for use (IFU) must be adhered to when evaluating reprocessing of SUD.

3.5 Reprocessing a SUD may affect the function of the device and/or material from which the device is made. Single – use devices may not be designed to allow for through decontamination and re-sterilization process. Unforeseen problems such as inadequate decontamination, material alteration, mechanical failure, and residual chemical agents can render the reprocessed item unsafe. In addition, validation of the SUD's functionality after reprocessing cannot be guaranteed.

4.PROCEDURE

4.1. SUDs must be discarded by the end user at the point of use as per hospital waste disposal protocol.

4.2. Examine used SUDs being considered for reuse on an individual basis and consider potential risk implications as follows:

4.2.1. Describe the item.

4.2.3. Use of the item (i.e., invasive (critical) vs. non-invasive (non-critical)).

4.2.4. Availability of manufacturer's IFU reprocessing instructions.

4.2.5. Risks to the patient (i.e., infection and/or mechanical defects causing injury).

4.2.6. Quantity to be reprocessed. f. Cost per item.

4.2.7. Is it a stock item?

4.2.8. Nil stock (none in supply stores).

4.2.9. Next delivery date.

4.2.10. Ethical, moral, and legal implications.

4.3. Fill out a hospital standard written request for evaluation of the SUD.

4.3.1. If reuse of a SUD is considered, the conclusion must be influenced by unique circumstances pertaining to the individual device. Complete the attached evaluation form and forward it to Infection Prevention and Control (IP&C) Department .



CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTMENTAL POLICY & PROCEDURE			
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4.3.2. If re-sterilization of unopened expired devices or opened unused devices is considered, the conclusion must be guided by the manufacturer's instructions/recommendations. Obtain and complete the appropriate form from Central Sterile Supply Department (CSSD)

4.4. Submit the SUDs in its original packaging with all pertinent IFU along with a written request to the CSSD supervisor for review and assessment.

4.5. The CSSD supervisor assesses the item and discusses the findings with the IP&C to determine the appropriate course of action with the following consideration:

- 4.5.1. Risks involved with product safety and performance.at the front of the mask.
- 4.5.2. Method of re-sterilization.
- 4.5.3. Frequency of re-sterilization.
- 4.5.4. Quality control.

5. RESPONSIBILITY

5.1 SUD COMMITTEE MEMBARE

6. ATTACHMENT:

6.1 Form 1-IX-03: Evaluation for Reprocessing Single Use Items/Devices



Kingdom Of Saudi Arabia
Ministry Of Health
Jazan Health Directorate
Al-Harth General Hospital



CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTMENTAL POLICY & PROCEDURE			
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Form 1-IX-03: Evaluation for Reprocessing Single Use Items/Devices

Requestor		Date	
Name		Badge#	
Title		Department	
	Questions	Yes/No	Describe
1	Describe the item expiration date		
2	Use of item (invasive or non-invasive		
3	Provide manufactures reprocessing instructions		
4	Risks to the patient?		
5	Quantity to be reprocessed?		
6	Cost per item?		
7	Is it stock item? Oracle#		
8	Special purchase request (SPR#(
9	Nil stock?		
10	Next delivery date		
Infection control department			
Evaluator		Date:	
		Badge#	
Findings:			
Action:			



CENTRAL STERILIZATION SUPPLY DEPARTMENT

DEPARTMENTAL POLICY & PROCEDURE

DPP

VERSION:2

POLICY NUMBER:	DPP-CSSD-019	APPLIES TO: CSSD PERSONNEL
TITLE:	TRANSPORT OF SOILED ITEMS	
APPROVAL DATE:	JUL 30,2021	EFFECTIVE DATE : AUG 30,2021
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